Health and care working together
in South Yorkshire and Bassetlaw

South Yorkshire and Bassetlaw - Commissioning for Outcomes Policy

FINAL (v23)

Version Control

Version	Date	Author	Changes
V1.0	01/04/2015	Dr Sarah Lever	
V1.1	19/06/2015	Hilary Porter	Added wording specifically excluding tonsillectomy as part of cancer treatment/management
V1.2	24/08/2015	Rebecca Chadburn	Change of email address
V2	28/07/16	Dr Sarah Lever	Renamed Clinical thresholds policy with 7 additional clinical thresholds added. Changes to process for referral and approval for treatment. Prior approval only required when deemed exceptional
V3		Dr Sarah Lever	Renamed South Yorkshire and Bassetlaw Commissioning for Value policy. Additional clinical thresholds added and commissioning policy made expressly clear for all procedures including, cosmetic, plastic and fertility procedures.
V8	4/09/2017	Jack Harding	Formatting
V15	20/12/17	Jack Harding	Includes updated links to IFR policies and ACS website
V16	13/02/2018	Adele Spence	Includes previous omission regarding BMI for Doncaster breast augmentation
V17	16/02/18	Abigail Tebbs	Includes changes for Sheffield position on Orthopaedic and cataract procedures
V18	07/08/18	Debbie Stovin	Indicates the elements where Sheffield have opted out
V19	16/11/18	Julie Shaw	Includes changes to Cataracts policy and checklist and the Varicose Veins checklist
V20	01/02/19	David Lautman	Updated to incorporate National Evidence Based Interventions (EBI) Guidance. Local evidence based interventions and specialist plastics policies also reviewed and updated as part of annual review.
V21	01/05/19	David Lautman	To incorporate EBI mobilisation feedback and Governing Body feedback.
V22	01/04/2020	David Lautman	To incorporate additional National EBI guidance and annual review.
V23	7/2/21	Michele Clarke	To incorporate the 31 EBI Phase 2 interventions 2020

This policy is hosted on the South Yorkshire and Bassetlaw Integrated Care System website and can be accessed at: https://sybics.co.uk/transformation/useful-documents

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1. Executive Summary

Now more than ever, it is important for the NHS to demonstrate that it is making the most effective use of public monies to maximise the health and wellbeing of the people of South Yorkshire and Bassetlaw (SY&B). We need to ensure that our resources are used wisely to maximise the impact of the services we commission to improve health, reduce health inequalities and ensure our population receives appropriate high quality evidence based clinical care.

We seek to ensure that our commissioning decisions are fully informed and based on the best evidence available and provide best value for money. To fulfil these aims, SY&B Commissioners have agreed a regional wide Commissioning for Outcomes (CFO) Evidence Based Interventions Policy. The Policy sets out our approach and governance arrangements to ensure that as far as possible, our decisions are robust, rational and justifiable.

2. Introduction

The purpose of this Policy is to establish a system for transparent and coherent prioritisation for the commissioning of health and wellbeing services. It provides a framework for making decisions about relative priorities at a strategic and planning/commissioning level and facilitates rational and reasonable decisions about which services are commissioned in accordance with the SY&B Integrated Care System (ICS).

The Policy applies to all commissioning decisions made by SY&B CCGs and should be applied when healthcare interventions can no longer be prioritised on the basis of clinical evidence, outcomes and value for money.

This policy links with our strategic plan and commissioning intentions available at the ICS Plan.

Commissioners will incorporate National Evidence Based Interventions guidance into this document in line with national process.

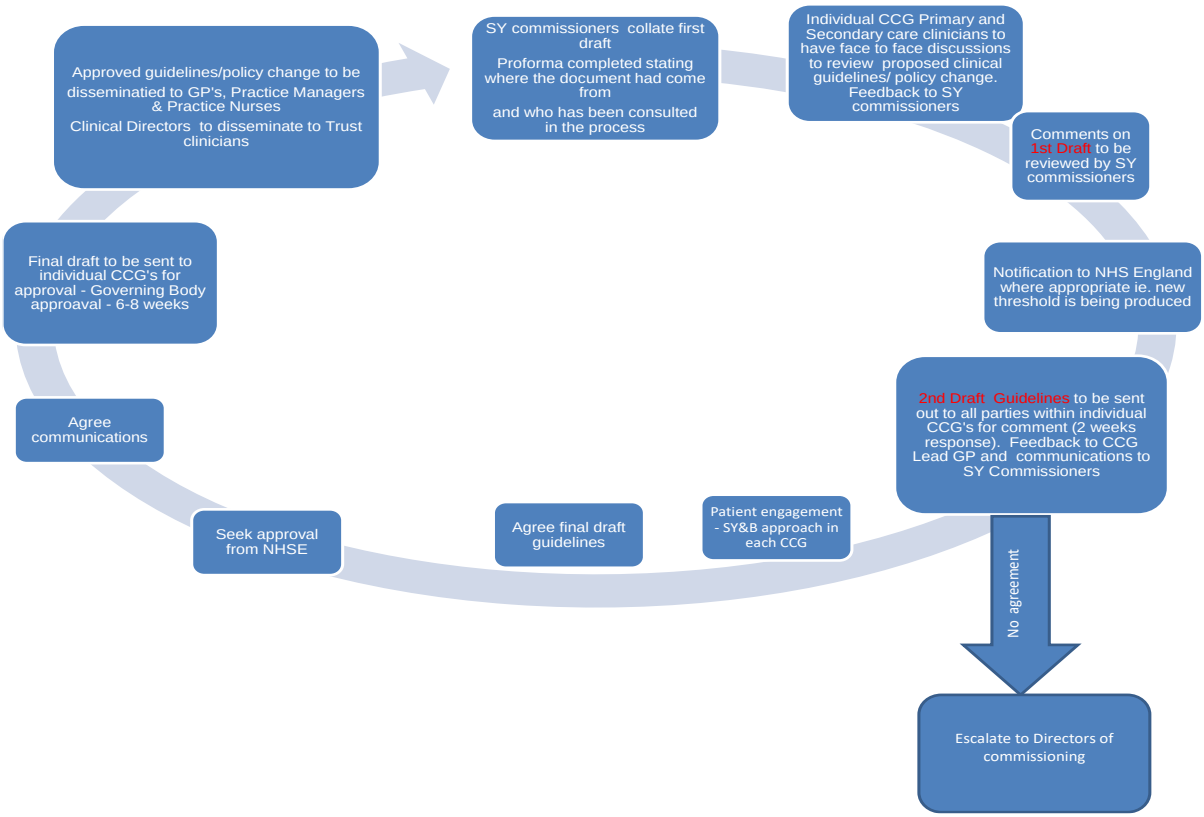
3. Decision Making and Prioritisation Approach

SY&B CCGs are required to make decisions about strategic and operational priorities for annual resource allocation. These may arise from:

- Business cases for investment in services
- Value for money reviews
- Performance monitoring of services or specific treatments where they no longer provide evidenced clinical value, outcomes and best value for money or are a lower priority than services we need to fund within our affordability envelope (including proposal for new Individual Funding Request (IFR) policies)
- Decisions required outside of our planning process on funding outside existing commissioned services and exceptionality for individual cases. This may apply in the following circumstances:
    - A new intervention is made available that is of significant importance
    - A new treatment or service is made available that provides such significant health or financial benefits
    - A proposal is submitted by an external body that provides benefits

SY&B CCGs work together to agree a common approach where decisions are not specific to individual CCGs and their providers. As legal entities, decisions are required by individual CCGs prior to implementation at a SY&B level. Accordingly, the decision making approach within individual CCGs is set out in Figure 1

Figure 1 SY&B process for decision making



4. Priorities for Annual Resource Allocation

SY&B CCGs will prioritise existing resources, reconsider commissioned services that are not considered to be delivering the expected health benefit and consider any new services or business cases to ensure that we are utilising our resources effectively. Local needs and national benchmarking information, where appropriate, will guide CCGs in this prioritisation of expenditure at a local level between commissioning programmes. The following criteria will be used for consideration:

- Alignment with the SY&B Integrated Care System
- Alignment with the CCGs' strategic objectives or national mandatory priorities
- Benefits and outcomes are identified and evidenced/measurable
- Compliance with any legal and clinical frameworks or guidance and procurement processes
- Response to a need that has been assessed
- Clinical effectiveness, outcomes including assessment by NICE or other evidence-based review
- Impact on health inequalities and protected characteristics
- Will improve patient safety and experience
- Accessibility to service users
- Affordability and value for money

5. Service Developments

SY&B commission services in line with NICE Guidance. There is a contractual requirement for providers to treat in line with NICE guidance.

The CCGs will not introduce new drugs/technologies on an ad hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal need. There is also the risk that diversion of resources in this way will de-stabilise other areas of health care which have been identified as priorities by the CCGs.

The CCGs expect consideration of new drugs/technologies to take place within the established planning frameworks of the NHS. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal need.

The CCGs have a default policy of not funding a treatment where no specific policy exists to approve funding for the treatment. If the CCGs or an individual CCG has not previously been asked to fund an intervention that has the potential to affect a number of patients, applications should be made by clinicians for the CCGs/CCG to consider the intervention through its general commissioning policy and not by way of an IFR application.

Interventional Procedure Guidance issued by NICE will be deemed by the CCGs as a Service Development and will not be routinely funded by the CCGs unless agreed in advance.

6. Scope of Document

SY&B Commissioning for Outcomes Policy covers the following:

- National Evidence Based Interventions Phase 1
  - Category 1 Interventions – Procedures not routinely commissioned
  - Category 2 Interventions – Criteria Led
- National Evidence Based Interventions Phase 2
  - Category 1 Interventions – Procedures not routinely commissioned
    Category 2 Interventions – Criteria Led
- Local Evidence Based Interventions
  - Procedures not Routinely Commissioned
  - Criteria Led
- The SY&B Commissioning Guidelines for Plastic Surgery Procedures which have been incorporated into this document
- The Y&H Fertility Policy which has been incorporated into this document

Age Range: This policy applies to both adults and children unless specified otherwise.

This document sets out:

- The procedures covered by this policy
- The referrals process including the use of the IFR process where prior approval is required or there is a case for exceptionality.
  Note: Procedures which are not routinely commissioned require prior approval through the Individual Funding Request Panel (Section 11).
- The interventions and threshold for treatment
- Monitoring arrangements
- Rules around payment
- Referral checklists
- Patient information sheet

7. Review

This policy will be reviewed on an annual basis.

Date of next Review: March 2022

Part 2
Interventions and Process for Referral

8. **National Evidence Based Interventions Phase 1 and Phase 2 and Local Evidence Based Interventions – Clinical responsibilities**

Table 1 below lists the interventions to which the national Evidence Based Interventions Policy Phase 1 and Phase 2 applies. It incorporates procedures not routinely commissioned and procedures criteria led.

Table 1 also incorporates the Local Evidence Based Interventions for procedures not routinely commissioned and procedures criteria led.

Key

Speciality	Speciality of Intervention
Ref No	Indicates Phase 1 (1) or Phase 2 (2) or Local Evidence Based Intervention (LEBI)
Intervention	Intervention description
Category	Indicates source of intervention (Evidence Based Interventions - Phase 1 [EBI1] or Phase 2 [EBI2] or Local Evidence Based Interventions [LEBI])
Process	Indicates if checklist if relevant, recommends message on ICE system or IFR to be considered
Page Number	Policy - Page number of full detail of intervention Checklist - Page Number of checklist for Primary or secondary care if applicable (Secondary care checklists to be adopted if desired)

Table 1

1 = Phase 1 EBI, 2= Phase 2 EBI and LEBI = Local Evidence Based Interventions

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if applicable OR ICE
ANAESTHETICS	2AA	Pre-operative Chest X-ray (before an operation)	EBI 2	Refer to guidance on ICE	Refer to guidance on ICE	25	119
	2BB	Pre-operative ECG - Heart tracing (ECG) before an operation	EBI 2	Refer to guidance on ICE	Refer to guidance on ICE	25	120

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if applicable OR ICE
CARDIOLOGY	2A	Diagnostic coronary (invasive) angiography for low risk, stable chest pain	EBI 2		Complete secondary care checklist	25	111
	2F	Specialised blood tests (troponin) for investigation of chest pain	EBI 2	Refer to guidance on ICE	Refer to guidance on ICE	25	114
	2L	Exercise ECG for screening for coronary heart disease	EBI 2	Not routinely commissioned Referral to IFR panel		25	
	2DD	Lipid Lowering Therapy - Regular blood tests when taking cholesterol lowering tablets	EBI 2	Education and refer to guidance on ICE	Education and refer to guidance on ICE	26	121
DERMATOLOGY	1F and LEBI	Removal of Benign Skin Lesions and Removal of Benign Perianal skin lesions	EBI 1/LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	26	67 and 83
ENT	1A	Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))	EBI 1	Not routinely commissioned Referral to IFR panel		27	
	1G	Grommets in children	EBI 1	Complete the checklist and attach to referral letter	Complete relevant secondary care section of checklist	27	69
	1H	Tonsillectomy	EBI 1	Prior Approval via IFR (Clinical Letter and Checklist)	Ensure Prior Approval in place prior to listing patient Notification to IFR panel for biopsy or removal of lesion (prior approval not required).	29	69

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if applicable OR ICE
ENT	2C	Surgery for chronic sinusitis	EBI 2	Complete the checklist and attach to referral letter	Complete relevant secondary care section of checklist	32	100/110
	2D	Removal of the adenoids (for glue ear and not OSA) Adenoidectomy	EBI 2		Complete relevant secondary care section of checklist (Requires IFR approval)	32	111
	LEBI	Grommets in Adults	LEBI	Complete the checklist and attach to referral letter	Complete relevant secondary care section of checklist IFR for exceptionality	32	82

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
GENERAL SURGERY	1I	Haemorrhoid Surgery	EBI 1	Complete the checklist	Check and accept checklist. IFR for except	34	72
	2B	Surgical repair of hernias	EBI 2/LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	35	88
	2M	Upper GI Endoscopy to investigate gut problems	EBI 2		Complete the relevant checklist	37	97
	2N	Appropriate Colonoscopy of the lower intestine	EBI 2	Complete the relevant checklist	Complete the relevant checklist	37	102
	2O	Repeat / Follow up colonoscopy of the lower intestine	EBI 2		Complete the relevant checklist	37	104
	2P	Test of the gallbladder - ERCP in acute gallstone pancreatitis without cholangitis	EBI 2		Refer to guidance on ICE	37	115
	2Q and LEBI	Cholecystectomy - Removal of an inflamed gallbladder	EBI 2/LEBI		Complete secondary care checklist. IFR for exceptionality	38	84
	2R	Appendicectomy without confirmation of appendicitis - Tests to confirm appendicitis	EBI 2		Refer to guidance on ICE	41	115
	LEBI	Ingrown toenail	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	41	95

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
GYNAECOLOGY	1J	Hysterectomy for management of heavy menstrual bleeding	EBI 1	Checklist from GP not required	Complete and sign checklist	41	73
	1B	Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women	EBI 1	Not routinely commissioned	Referral to IFR panel	42	
HAEMATOLOGY	2EE	Blood transfusions	EBI 2		Refer to guidance on ICE	42	122
OPTHALMOLOGY	1K	Meibomian cyst (Chalazion)	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	43	74
	LEBI	Upper Eyelid Blepharoplasty	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	43	86
	LEBI	Cataract Surgery	LEBI	Optometrist completes and signs checklist. Complete relevant secondary care section of checklist and check and electronically sign/accept the checklist. (The checklist must be completed for second eye surgery if required). If a Cataract LES or locally commissioned service is in place: Where a patient has been referred outside of the Cataract LES, the receiving clinician must ensure that the patient meets the threshold.		44	87

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
ORTHOPAEDICS	1C	Knee arthroscopy for patients with osteoarthritis	EBI 1	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).		47	
	1D	Injection for non-specific low back pain	EBI 1	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).		47	
	1L	Arthroscopic Subacromial Decompression of the shoulder (ASAD)	EBI 1	Primary care checklist/secondary care checklist *Sheffield CCG - Referrals will be made to the MSK service who will apply the criteria (checklist not required)*		48	75
	1M	Carpal tunnel Syndrome Surgery	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	49	76

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
ORTHOPAEDICS	1N	Common Hand Conditions - Dupuytrens release	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	49	77
	1O	Common Hand conditions - Ganglion	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	50	78
	1P	Common Hand Conditions - Trigger finger	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	50	79
	2E	Knee arthroscopic surgery for meniscal tears	EBI 2		Complete relevant checklist	50	106
	2J	Lumbar Discectomy - Spinal surgery for a slipped disc	EBI 2		Complete relevant checklist	50	113
	2K	Lumbar Radiofrequency facet joint denervation	EBI 2	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11)		50	

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
ORTHOPAEDICS	2S	Low back pain imaging	EBI 2	Refer to guidance on ICE (not routine investigation)		50	115
	2T	Knee MRI when symptoms are suggestive of osteoarthritis	EBI 2	Refer to guidance on ICE	Refer to guidance on ICE	50	116
	2U	Knee MRI for suspected meniscal tears	EBI 2		Check and electronically sign/accept the checklist	51	101
	2V	Vertebral augmentation (vertebroplasty or Kyphoplasty) for painful osteoporotic vertebral fractures	EBI 2	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).		52	
	2W	Imaging for shoulder pain	EBI 2	Refer to guidance on ICE		52	117
	2X	MRI scan of the hip for arthritis	EBI 2	Refer to guidance on ICE		52	118
	2Y	Surgery to fuse the bones in the back for back pain - Fusion surgery for mechanical axial low back pain	EBI 2	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).		52	

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
ORTHOPAEDICS	LEBI	Hallux valgus surgery	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	53	90
	LEBI	Total Knee replacement	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	55	93
	LEBI	Total Hip Replacement	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	55	91
PAEDIATRICS	2Z	Helmet therapy in the treatment of positional plagiocephaly in children*	EBI 2	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11)		58	
PAIN CLINIC	LEBI	Acupuncture for non-specific back pain	LEBI	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11)		58	

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
PLASTICSURGERY (All summarised in appendix 3)	1E and LEBI	Plastic surgery procedures	EBI 1 and LEBI	Prior Approval via IFR (Clinical Letter and Questionnaire)	Ensure Prior Approval in place prior to listing patient	59	
UROLOGY	2G	Surgical removal of kidney stones	EBI 2		Complete appropriate checklist	60	108
	2H	Cystoscopy for men with un-complicated lower urinary tract symptoms	EBI 2	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	60	1107
	2I	Surgical intervention for benign prostatic hyperplasia	EBI 2		Complete appropriate checklist	60	109
	2CC	Prostate- specific antigen (PSA) testing	EBI 2		Refer to guidance on ICE	60	120
	LEBI	Male circumcision	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	60	96
	LEBI	Vasectomy under GA	LEBI	Prior Approval via IFR (Clinical Letter and Questionnaire)	Ensure Prior Approval in place prior to listing patient	62	
VASCULAR	1Q	Varicose veins	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	62	80

9 Making a Referral

Where an evidence-based threshold applies, clinicians are required to complete the referral checklist and attach the document to the referral. Referrals without a completed checklist will be returned to the referral source indicating the reason for rejection. The provider will confirm that the electronic checklist is present and that the patient meets the threshold, criteria. The secondary care element of the referral checklist will be completed (where this applies to an intervention) and electronically signed/accepted by the receiving clinician to evidence that the patient meets the criteria. The referral checklist will be included within the patient notes / filed for future compliance audit.

A referral should only proceed to treatment if the patient meets the threshold or specific criteria in the category 2 intervention and a completed and compliant referral checklist is in place.

In some circumstances, GPs, Consultants or NHS clinicians may consider an individual has exceptional clinical circumstances and may benefit from a treatment which is not routinely provided. Requests for such treatments must be made through an Individual Funding Request (IFR) by the clinician. This request will then be considered, approved or rejected by an independent panel. The referral process is illustrated at **Diagram 1.**

Consultant to Consultant referrals for hysterectomy for heavy menstrual bleeding must comply with the Consultant to Consultant Policy. In these circumstances the receiving Consultant must complete a checklist to indicate whether or not the patient meets the Threshold criteria. Any qualifying evidence must also be documented within the patient's medical records.

Table 1 (page 9 -18) show the responsibilities of the clinician for each condition.

The criteria for treatment and referral checklists for each procedure are set out in **Part 3** of this document. Where patients do not meet the criteria for referral they should be advised to return to their GP or other appropriate health care professional should their condition change. Likewise, where patients are on a pathway for elective care, clinical review should be available where necessary should a patient's condition require earlier intervention.

Health Improvement Programmes
NHS Barnsley and Rotherham CCGs have introduced health and wellbeing initiatives that encourages patients who are smokers and/or have a Body Mass Index (BMI) of 30 or over to ensure they are in the best possible health before they go for a routine, non-urgent operation. Patients will receive support to stop smoking and/or lose weight.

Barnsley and Rotherham CCGs do not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients (over 18 years old) who are active smokers or whose BMI is 30 or more (See separate commissioning policy for groups who are exempt)

In Barnsley the programme is called 'Get Fit First' for surgery. In Rotherham the programme is called 'Fitter Better Sooner'.

<u>Get Fit First in Barnsley (For Barnsley CCG patients only)</u>
The Get Fit First Programme is a health and wellbeing initiative introduced by NHS Barnsley Clinical Commissioning Group that encourages patients who are smokers and/or have a Body Mass Index (BMI) of 30 or over to ensure they are in the best possible health before they go for a routine, non-urgent operation. Patients will receive support to stop smoking and/or lose weight.

Barnsley CCG does not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients (over 18 years old) who are active smokers or whose BMI is 30 or more (See separate commissioning policy for groups who are exempt)

- Evidence of smoking abstinence will be required prior to referral for surgery. Patients who stop smoking can be referred after 12 weeks. Patients who do not stop smoking will be referred for surgery after 6 months from initial consultation and advised to abstain from smoking for a minimum of 2 days prior to surgical intervention. This will allow a period of health improvement.
- Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 6 months from initial consultation (subject to clinical opinion).

Note: Some interventions in this policy include a specific BMI as part of the criteria for referral; Varicose Vein surgery (BMI 30), Specialist Plastics Policies (BMI 18.5 – 27). The completion of 6 months health improvement does not overrule these specific BMI criteria. For Hip / Knee Replacement the previous BMI requirement (35) is replaced with 'Patient meets Get Fit First criteria'.

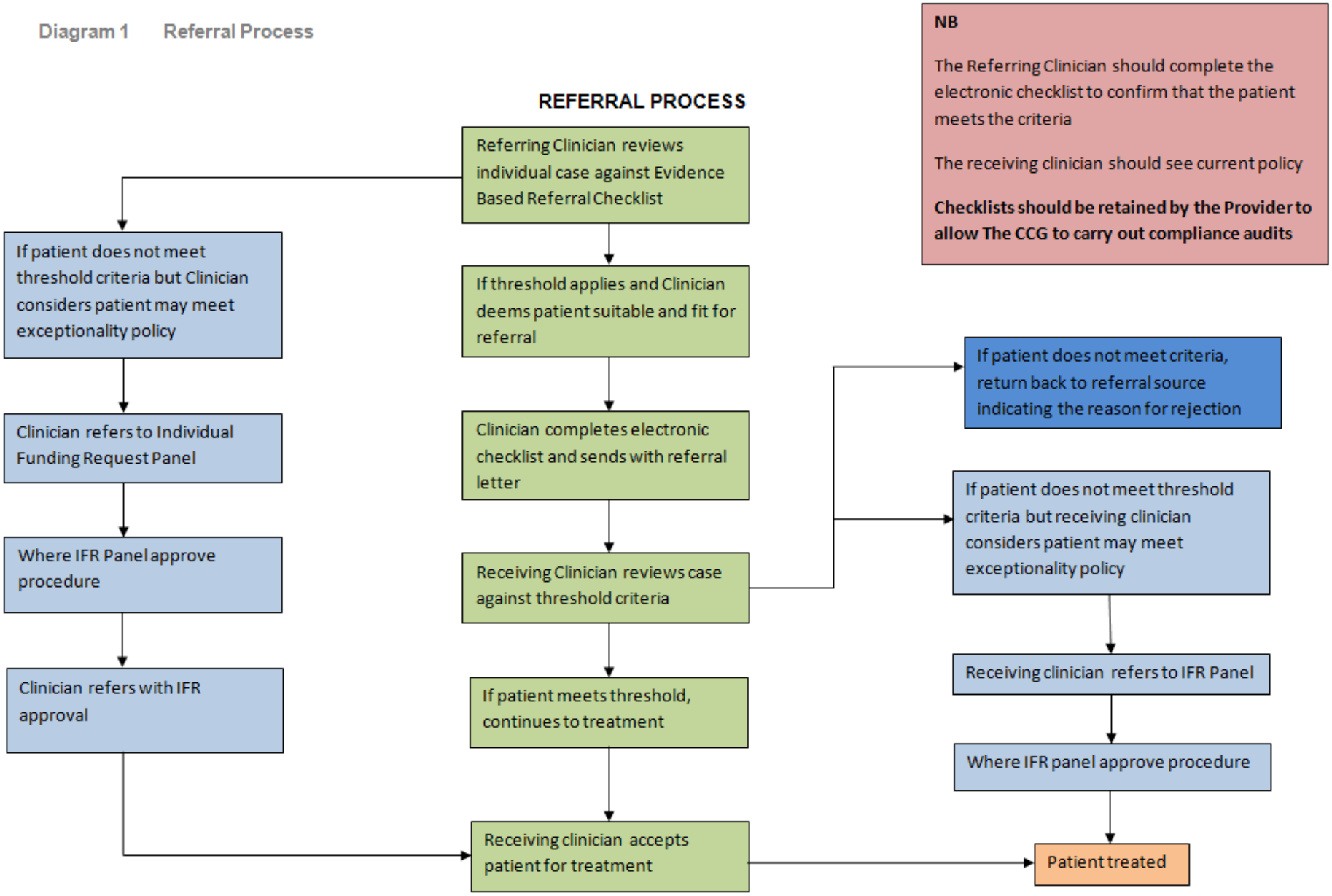
For further information about the initiative visit http://www.barnsleyccg.nhs.uk/patient-help/getfitfirst

Fitter Better Sooner (Rotherham CCG patients only)

- Evidence of smoking abstinence will be required prior to referral for surgery. Patients who stop smoking can be referred after 12 weeks. Patients who do not stop smoking will be referred for surgery after 9 months from initial consultation and advised to abstain from smoking for a minimum of 2 days prior to surgical intervention. This will allow a period of health improvement.
- Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 9 months from initial consultation (subject to clinical opinion).

Note: Some interventions in this policy include a specific BMI as part of the criteria for referral; Varicose Vein surgery (BMI 30), Specialist Plastics Policies (BMI 18.5 – 27). The completion of 6 months health improvement does not overrule these specific BMI criteria. For Hip / Knee Replacement the previous BMI requirement (35) is replaced with 'Patient meets Fitter Better Sooner criteria'.

Diagram 1 Referral Process



10. Individual Funding Requests (IFR)

If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments, then they must be referred to the IFR Panel.

The criteria for treatment and referral checklists for each intervention are set out in Part 3 of this document.

11. Prior approval for treatment outside of this policy

Table 1 (pages 9 to 18) make clear the requirements of the referring and receiving clinician for evidence based interventions. Clinicians will seek prior approval for treatment where patients are to be treated outside of these policies. Where a clinician believes that a patient might benefit from an intervention but where they do not meet the clinical threshold, the clinician may apply to the IFR Panel to make the case for exceptionality. In these circumstances clinicians will be required to evidence the reasons for exceptionality. Where a procedure has a BMI restriction, patients whose high BMI is due to bulk muscle should be referred to the IFR panel as an exception.

12. Exceptionality

The CCG commissions according to the policy criteria. Requests for individual funding can be made only where exceptional circumstances exist and can be made through the NHS Individual Funding Request (IFR) procedure.

Responsibility for demonstrating exceptionality rests with the referring clinician.

A patient may be considered exceptional to the general standard policy if both the following apply:

- He/she is different to the general population of patients who would normally be refused the healthcare intervention, and
- There are good grounds to believe that the patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with that particular condition.

In assessing exceptionality, the IFR panel will not consider social, demographic or employment circumstances.

Where a patient has already been established on a health care intervention, for example as part of a clinical trial or following payment for additional private care, this will be considered to neither advantage nor disadvantage the patient. However, response to an intervention will not be considered to be an exceptional factor.

The IFR policy for each CCG is shown in **Appendix 7**.

Where prior approval is required it should be sought from the CCG in advance of the treatment being provided.

All requests should be sent to:

Individual Funding Requests
722 Prince of Wales Road,
Sheffield,
S9 4EU

or sent electronically to: sheccg.sybifr@nhs.net, or by fax to: 0114 3051370 (safe haven) adhering to confidentiality procedures. Only requests by letter will be accepted. A clinical letter with a completed checklist (where relevant) should be sent to the IFR panel outlining why the patient does not meet the criteria and evidence supporting their exceptionality.

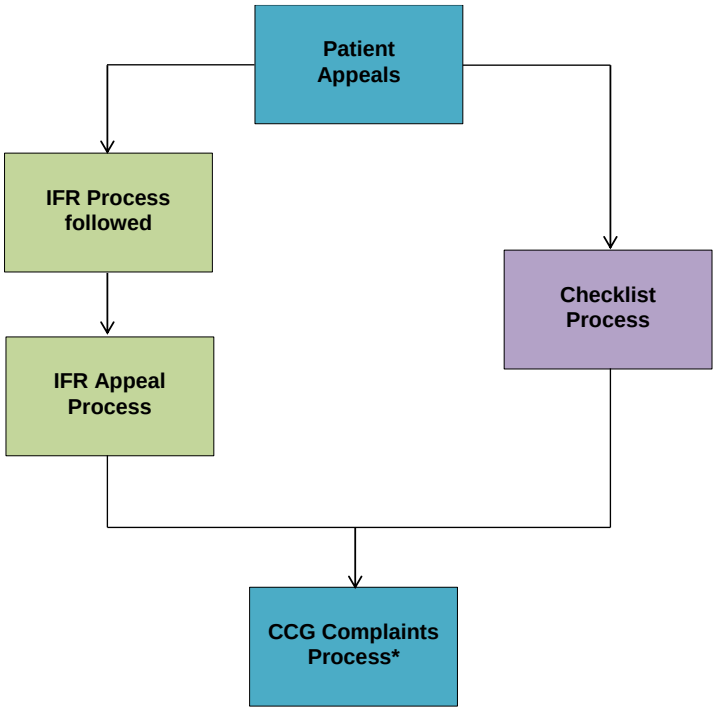
Service Condition 29.26 of the NHS Standard Contract makes clear that failure by the commissioner to respond within the agreed timescale may be taken as approval to treat. The IFR team aims to process requests through the panel within 14 days and request further information from the GP where required.

13. Appeals

SY&B CCGs recognise that there may be times when members of the public are dissatisfied with the decisions. We are committed to undertaking engagement and consultation work that, at a minimum meets national expectations of best practice, and believe that doing so will help ensure our decisions are in the interests of the public of SY&B.

Any patient/carer who feels that a decision is not justified may register a complaint or appeal, as per the below process. Ultimately, the CCGs' decisions may be the subject to legal challenge from individuals or groups.

Figure 2- Patient Appeals Process



***Individual CCG complaints processes are detailed at the following Link**

Part 3
Summary of Commissioning Position and Evidence Base

14. List of Procedures/Interventions including National Local Based Interventions Phase 1 and Phase 2 and Local Based Interventions. (Not routinely commissioned and criteria Led)

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Anaesthetics	2AA	**Pre-operative Chest X-ray (before an operation)**	Not routinely commissioned	**National Evidence Based Interventions Policy P.69** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
	2BB	**Pre-operative ECG - Heart tracing (ECG) before an operation**	Not routinely commissioned	**National Evidence Based Interventions Policy P.70** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
Cardiology	2A	**Diagnostic coronary (invasive) angiography for low risk, stable chest pain**	National Based Interventions policy	**National Based Interventions policy: P.11** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Complete secondary care checklist
	2L	**Exercise ECG for screening for coronary heart disease**	Not routinely commissioned	**National Evidence Based Interventions Policy P.32** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
	2F	**Specialised blood tests (troponin) for investigation of chest pain**	National Based Interventions policy	**National Based Interventions policy: P.21** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
	2DD	**Lipid Lowering Therapy - Regular blood tests when taking cholesterol lowering tablets**	National Based Interventions policy	National Based Interventions policy: P.75 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Education and refer to message on ICE
Dermatology	1F	**Removal of Benign Skin Lesions**	National Evidence Based Interventions Policy and Local Based Interventions	For Benign Skin Lesions SY&B commissioners have elected to maintain the existing referral checklist (which is in line with the EBI policy) as the national criteria are very broad and unmanageable via checklist in long-form. To ensure the referral process is manageable the checklist groups the criteria where a lesion might be removed. Any patients that do not meet the threshold criteria can be referred to the IFR panel who will assess patients against the EBI guidance. **National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
	LEBI	**Benign Perianal Skin Tags**	Local Evidence Based interventions – criteria led Referral should only be undertaken when one or more of the following criteria have been met:	**For Local Evidence Base and Criteria See Appendix 2** **NHS England.** Interim Clinical Commissioning Policy: Anal Skin Tag Removal https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC002.pdf **McKinnell and Gray**, 2010,	Refer using checklist. IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			• There is doubt about the benign nature of the skin lesion • Viral warts in immunocompromised patients where underlying malignancy may be masked. Recommended by GU Med when conservative treatment has failed	QIPP Programme Right Care: Value Improvement Identifying Procedures of Low Value, Public Health Commissioning Network. **NHS Choices** Lumps and swellings http://www.nhs.uk/conditions/lumps-swellings/Pages/Introduction.aspx (accessed January 2017)	
ENT	1A	**Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))**	Cat 1 . Not routinely commissioned	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **2020/21 National Tariff Payment System – a consultation notice**https://improvement.nhs.uk/documents/6257/2021_NTPS_statutory_consultation_notice.pdf (page 132)	exceptionality can be applied for via a clinical letter to the IFR panel.
	1G	**Grommets in children**	The CCG will **only** fund grommet insertion in children (age under 18 for Barnsley/Doncaster/ Bassetlaw/Rotherham or 16 and under for Sheffield) when one or more of the following criteria are met: • Recurrent otitis media – 5 or more recorded episodes in preceding 12 month period	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention - refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT			• Suspected hearing loss at home or at school / nursery • Speech delay, poor educational progress due to hearing loss, following 3 months of watchful waiting • Abnormal appearance of tympanic membrane • Persistent hearing loss for at least 3 months with hearing levels of: 25dBA or worse in both ears on pure tone audiometry **OR** 25dBA or worse or 35dHL or worse on free field audiometry testing **AND** Type B or C2 tympanometry • Suspected underlying sensorineural hearing loss • Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk • OME in the presence of a secondary disability e.g. autistic spectrum disorder, Down Syndrome, cleft palate • Persistent OME (more than 3 months) with fluctuating hearing but significant		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			delay in speech, educational attainment or social skills. This policy applies to all tubes inserted into the tympanic membrane to aid ventilation and pressure equalisation of the middle ear. This includes grommets - myringotomy tubes - and tympanostomy or T tubes. National Evidence Based Interventions policy only applies to glue ear (otitis media with effusion). The CCG will routinely fund additional conditions which are detailed in Appendix 2 provided a checklist is completed to evidence a patient meets the criteria.		
ENT	1H	**Tonsillectomy** **(Significant changes to criteria 2021)**	The CCG will **only** fund tonsillectomy when one or more of the following criteria have been met: **Primary care assessment-** • Recurrent attacks of tonsillitis as defined by: Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning **AND**	SY&B Commissioners noted that referrals for tonsillectomy for recurrent tonsillitis require additional clinical input to assess against national criteria (number of occurrences of sore throats) hence the recommendation to use IFR	Prior Approval via IFR (Clinical Letter and Checklist) Notification via IFR is NOT required for biopsy or

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT			7 or more well documented, clinically significant *, adequately treated episodes in the preceding year **OR** • 5 or more such episodes in each of the preceding 2 years **OR** • 3 or more such episodes in each of the preceding 3 years **A Clinically significant episode is characterised by at least three of the following (Centor criteria):* *-Tonsillar exudate* *-Tender anterior cervical lymphadenopathy or lymphadenitis* *-History of fever (over 38'C)* *-Absence of cough* Two or more episodes of quinsy (peritonsillar abscess) • Severe halitosis secondary to tonsillar crypt debris • Failure to thrive (child) secondary to difficulty swallowing caused by enlarged tonsils • Obstructive sleep disordered breathing causing severe daytimeand night time symptoms. Primary care clinicians should send a brief referral letter and a copy of the checklist to IFR for prior approval	**Burton MJ, Glasziou PP.** Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. *Cochrane Database of Systematic Reviews* 1999, Issue 3. Art. No.: CD001802. First published online: July 26 1999. Available from: http://www.cochrane.org/reviews/en/ab001802.html (accessed 2019) **Osbourne MS, Clark MPA.** The surgical arrest of post-tonsillectomy haemorrhage: Hospital Episode Statistics 12 years on. Annals RCS. 2018.May (100) 5: 406-408 **Paradise JL, Bluestone CD, Bachman RZ.** Efficacy of tonsillectomy for recurrent throat infection in severely affected children. Results of parallel randomized and non-randomized clinical trials. N England J Med 1984:310(11):674-83 **Rubie I, Haighton C, O'Hara J, Rousseau N, Steen N, Stocken DD, Sullivan F, Vale L, Wilkes S, Wilson J**. The National randomised controlled Trial of Tonsillectomy IN Adults (NATTINA): a clinical and cost-effectiveness study: study protocol for a randomised control trial. Trials. 2015 Jun 6;16:263. https://www.ncbi.nlm.nih.gov/pubmed/26047934 (accessed 2019) **Scottish Intercollegiate Guidelines Network**	removal of lesion The IFR panel will provide clinical oversight on the management of these policies. Refer through IFR for exceptionality.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			Secondary care assessment- • Obstructive sleep disordered breathing causing severe daytime and night time symptoms. Obstructive sleep disordered breathing is defined as: -Grade 3 or 4 tonsils AND -Symptoms persisting for more than three months AND -Night time symptoms- consistent snoring AND consistent wakefulness OR secondary enuresis OR witnessed apnoeas OR restlessness/excessive sweating AND • -Daytime symptoms- impaired school performance OR hyperactivity/aggression OR altered mood OR excessive tiredness Secondary care clinicians should send a clinical letter and copy of the GP referral to IFR for prior approval • Biopsy/removal of lesion on tonsil Secondary Care clinicians should send a clinical letter and copy of the GP referral to IFR for notification and monitoring (prior approval not required).	Management of sore throat and indications for tonsillectomy. A National clinical Guideline. April 2010 https://www.sign.ac.uk/assets/sign117.pdf (accessed 2019) **Safe Delivery Of Paediatric ENT Surgery In The UK: A National Strategy** https://www.entuk.org/sites/default/files/files/Safe%20Delivery%20Paediatric%20ENT.pdf (accessed 2020)	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT	2C	**Surgery for chronic sinusitis**	National Based Interventions policy	National Based Interventions policy:P.14 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Primary Care and secondary care checklist – IFR for exceptionality
ENT	2D	**Removal of the adenoids (for glue ear and not OSA) Adenoidectomy**	National Based Interventions policy	National Based Interventions policy:P.17 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care Management (Require IFR approval)
ENT	LEBI	**Grommets for adults**	**Adults** should meet at least one of the following criteria. • Persistent hearing loss for at least 3 months with hearing levels of 25dB or worse on pure tone audiometry **or** • Recurrent acute otitis media – 5 or more episodes in the preceding 12 month period **or** • Eustachian tube dysfunction causing pain **or** • Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk **or**	ENT UK 2009 OME/Adenoid and Grommet **Perera R.** Autoinflation for hearing loss associated with otitis media with effusion.(Cochrane review). In: Cochrane database of systemic reviews, 2006. Issue Chichester: Wiley Interscience. http://www.cochrane.org/CD006285/ENT_autoinflation-for-hearing-loss-associated-with-otitis-media-with-effusion-glue-ear **Fickelstein Y. et al.** Adult-onset otitis media with effusion. Archives of Otolaryngology -- Head & Neck Surgery, May 1994, vol./is. 120/5(517-27). **Dempster J.H. et al.**	Complete relevant primary/ secondary care section of checklist IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT			• As a conduit for drug delivery direct to the middle ear **or** • In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician. Part of a more extensive procedure at Consultant's discretion such as tympanoplasty, acute otitis media with facial palsy This policy applies to all tubes inserted into the tympanic membrane to aid ventilation and pressure equalisation of the middle ear. This includes grommets - myringotomy tubes - and tympanostomy or T tubes	The management of otitis media with effusion in adults. Clinical Otolaryngology & Allied Sciences, June 1988, vol./is. 13/3(197-9) **Yung M.W. et al.** Adult-onset otitis media with effusion: results following ventilation tube insertion. Journal of Laryngology & Otology, November 2001, vol./is. 115/11(874-8). **Wei W.I. et al**. The efficacy of myringotomy and ventilation tube insertion in middle-ear effusions in patients with nasopharyngeal carcinoma. Laryngoscope, November 1987, vol./is. 97/11(1295-8) **Ho W.K. et al**. Otorrhea after grommet insertion for middle ear effusion in patients with nasopharyngeal carcinoma. American Journal of Otolaryngology, January 1999, vol./is. 20/1(12-5) **Chen C.Y. et al.** Failure of grommet insertion in post-irradiation otitis media with effusion. Annals of Otology, Rhinology & Laryngology, August 2001, vol./is. 110/8(746-8) **Ho W.K. et al.** Randomized evaluation of the audiologic outcome of ventilation tube insertion for middle ear effusion in	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT				patients with nasopharyngeal carcinoma. Journal of Otolaryngology, October 2002, vol./is. 31/5(287-93) **Park J.J. et al.** Meniere's disease and middle ear pressure - vestibular function after transtympanic tube placement. ACTA OTOLARYNGOL, 2009 Dec; 129(12): 1408-13 **Sugaware K. et al.** Insertion of tympanic ventilation tubes as a treating modality for patients with Meniere's disease: a short- and long-term follow-up study in seven cases. Auris, Nasus, Larynx, February 2003, vol./is. 30/1(25-8) **Montandon P. et al.** Prevention of vertigo in Meniere's syndrome by means of transtympanic ventilation tubes. Journal of Oto-Rhino-Laryngology & its Related Specialties, 1988, vol./is. 50/6(377-81)	
General Surgery	1l	**Haemorrhoid surgery**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using primary care checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
General Surgery	2B and LEBI	**Surgical Hernia Repair** • **Inguinal** • **Femoral** • **Umbilical** • **Para-umbilical** • **Incisional**	Local Evidence Based interventions – criteria led and National Phase 2 Interventions ***Inguinal:*** Surgical treatment should only be offered when one of the following criteria is met: • Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living **OR** • The hernia is difficult or impossible to reduce, **OR** • Inguino-scrotal hernia, **OR** • The hernia increases in size month on month ***Femoral:*** All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation ***Umbilical/Para-umbilical and midline ventral hernias:*** Surgical treatment should only be offered when one of the following criteria is met: • pain/discomfort interfering with activities of daily living **OR**	**For Local Evidence Base and Criteria See Appendix 2** **National Based Interventions policy** EBI_list2_guidance_150321.pdf (aomrc.org.uk) **National Institute for Health and Care Excellence** (2004) laprascopic surgery for hernia repair. [TA83]. London: National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ta83 (Accessed 2016) **Medscape: *Hernias***. Available from: http://emedicine.medscape.com/article/775630-overview#a0104 (accessed 2016) **McIntosh A. Hutchinson A. Roberts A & Withers, H**. Evidence-based management of groin hernia in primary care—a systematic review. Family Practice, 2000;17(5), 442-447. GP notebook: *Paraumbilical hernias*. Available from: http://www.gpnotebook.co.uk/simplepage.cfm?ID=-1811546097&linkID=17862&cook=n (accessed 2016) **Friedrich M. Müller Riemenschneider F. Roll S. Kulp W. Vauth C. Greiner W & von der Schulenburg JM**. Health Technology Assessment of laparoscopic compared to conventional surgery with and without mesh for incisional hernia repair regarding safety, efficacy and cost-effectiveness. *GMS health technology assessment*. 2008;*4*.	Refer using checklist. IFR for exceptionality.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
General Surgery			• Increase in size month on month **OR** • to avoid incarceration or strangulation of bowel where • hernia is ≥ 2cm ***Incisional:*** Surgical treatment should only be offered the following criteria are met: Pain/discomfort interfering with activities of daily living	**Dabbas.** Frequency of abdominal wall hernias: is classical teaching out of date. JRSM *Short Reports*: 2011;2/5. **Fitzgibbons**. Watchful waiting versus repair of inguial hernia in minimally symptomatic men, a randomised controlled trial. *JAMA*: 2006;295, 285-292 **Purkayastha S. Chow A, Anthanasiou T, Tekkis P P & Darzi A**. Ingunal hernias. *Clinical evidence, 2008;*0412, 1462-3846 **Rosenberg J. Bisgaard T. Kehlet H. Wara P. Asmussen T. Juul P & Bay-Nielsen M.** Danish Hernia Database recommendations for the management of inguinal and femoral hernia in adults. *Dan Med Bull*, 2011;*58*(2), C4243. **Simons M P. Aufenacker T. Bay-Nielsen M. Bouillot J L. Campanelli G. Conze J & Miserez, M**. European Hernia Society guidelines on the treatment of inguinal hernia in adult patients. *Hernia*, 2009;*13*(4),343-403. **Primatesta P & Goldacre MJ.** Inguinal hernia repair: incidence of elective and emergency surgery, readmission and mortality. *International journal of epidemiology*, 1996;*25*(4), 835-839.	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
				Patient Care Committee & Society for Surgery of the Alimentary Tract. Surgical repair of incisional hernias. SSAT patient care guidelines. Journal of gastrointestinal surgery: official journal of the Society for Surgery of the Alimentary Tract. 2004;8(3), 369. **The Society for Surgery of the Alimentary Tract**. *Surgical Repair of Groin Hernias. Available from: http://www.ssat.com/cgi-bin/hernia6.cgi* (accessed 2016) **National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	
General Surgery	2M	**Upper GI Endoscopy to investigate gut problems**	National Based Interventions policy	National Based Interventions policy:P.34 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Primary and secondary care checklist
	2N	**Appropriate Colonoscopy of the lower intestine**	National Based Interventions policy	National Based Interventions policy:P.38 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Primary and secondary care checklist
	2O	**Repeat / Follow up colonoscopy of the lower intestine**	National Based Interventions policy	National Based Interventions policy:P.38 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary care checklist required
	2P	**Test of the gallbladder - ERCP in acute gallstone pancreatitis without cholangitis**	National Based Interventions policy	National Based Interventions policy:P.44 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Checklist not appropriate

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
	2Q and LEBI	**Cholecystectomy**	National Based Interventions policy Cholecystectomy for patients with moderate or severely symptomatic gallstones will be routinely funded Patients admitted to hospital with acute cholecystitis or mild gallstone pancreatitis should have an index cholecystectomy before discharge. *This guidance may not be applicable in patients with severe acute pancreatitis* Local Evidence Based interventions – criteria led The CCG will **only** support the funding of cholecystectomy **in mild or asymptomatic gallstones if one or more of the following criteria are met:** • High risk of gall bladder cancer, e.g. *gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer). (**Annual USS for smaller asymptomatic polyps)* • Transplant recipient (pre or post-transplant).	**For Local Evidence Base and Criteria See Appendix 2** National Based Interventions policy: P.45 EBI_list2_guidance_150321.pdf (aomrc.org.uk) **Sanders G, Kingsnorth AN**. Gallstones. *BMJ*. 2007;335:295-9. **Sakorafas GH, Milingos D, Peros G.** Asymptomatic cholelithiasis: is cholecystectomy really needed? A critical reappraisal 15 years after the introduction of laparoscopic cholecystectomy. *Dig Dis Sci*. 2007;52:1313-25. **Royal College of Surgeons** https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/gallstones--commissioning-guide.pdf **Behari A and Kapoor VK.** Asymptomatic Gallstones (AsGS) – To Treat or Not to? *Indian J Surg*. 2012;74: 4–12. **Tsirline VB, Keilani ZM, El Djouzi S *et al*.** How frequently and when do patients undergo cholecystectomy after bariatric surgery? *Surg Obes Relat Dis* 2013;1550-7289(13)00335-3. **Taylor J, Leitman IM, Horowitz M**. Is routine cholecystectomy necessary at the time of Roux-en-Y gastric bypass? *Obes Surg*. 2006;16:759-61.	Refer using secondary care checklist/ IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			• Diagnosis of chronic haemolytic syndrome by a secondary care specialist. • Increased risk of complications from gallstones, e.g. presence of stones in the common bile duct, stones smaller than 3mm with a patent cystic duct, presence of multiple stones. • Acalculus cholecystitis diagnosed by a secondary care specialist. **Exclusion Criteria:** The CCG **will not** support the funding of cholecystectomy for patients in the following scenarios: • Patients with gallstones who experience one episode of mild abdominal pain only which can safely be managed with oral analgesia in primary care/community setting. Such patients should be advised to follow a low fat diet and only require referral if: - they have further episodes, **OR**	**Caruana JA, McCabe MN, Smith AD *et al***. Incidence of symptomatic gallstones after gastric bypass: is prophylactic treatment really necessary? *Surg Obes Relat Dis*. 2005;1(6):564-7; discussion 567-8.	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			- their pain is not controlled by oral analgesia **OR** - is associated with other symptoms, i.e. vomiting • Asymptomatic gallstones in patients with diabetes mellitus. • Asymptomatic gallstones in patients undergoing bariatric surgery, unless intra-operatively the gall bladder is found to be abnormal or the presence of calculi are very apparent. In such cases it is worth considering concurrent cholecystectomy. • All patients with asymptomatic gallstones who do not meet any of the above criteria. Barnsley and Rotherham CCG patients who are asymptomatic will not be funded for cholecystectomy. Patients will be funded after one episode of mild pain		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
General Surgery	2R	**Appendicectomy without confirmation of appendicitis - tests to confirm appendicitis**	National Based Interventions policy	National Based Interventions policy: P.47 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Message on ICE
	LEBI	**Ingrown toe nail in secondary care**	Local Evidence Based interventions – criteria led Referral to secondary care should only be undertaken when: • the patient is in clinical need of surgical removal of ingrown toe nail, has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed. OR • People of all ages with infection and/or recurrent inflammation due to ingrown toenail AND who have high medical risk*. *Medical risk is determined by the referring clinician	For Local Evidence Base and Criteria See Appendix 2 Eekhof JAH, Van Wijk B, Knuistingh Neven A, van der Wouden JC. Interventions for ingrowing toenails. Cochrane Database of Systematic Reviews 2012, Issue 4. Art. No.: CD001541. DOI: 10.1002/14651858.CD001541.pub3 NICE (2016). Clinical Assessment Service: foot and ankle pathway | QP Case Study | Local practice | NICE. [online] Available at: https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3a%2f%2farms.evidence.nhs.uk%2fresources%2fQIPP%2f959489%2fattachment%3fniceorg%3dtrue	Refer using checklist. IFR for exceptionality For Sheffield CCG refer to community podiatry service who will determine if referral to secondary care is required.
Gynaecology	1J	**Hysterectomy for heavy menstrual bleeding**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf Patient choice regarding opting out of conservative treatment only applies to levonorgestrel intrauterine system or LNG-IUS and not to the whole pathway. If	Evidence Based Intervention – refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
				a patient declines any element then approval from IFR is required. Please note that dilatation and curettage (D&C) is NOT routinely commissioned to either diagnose or treat heavy menstrual bleeding, in line with the Evidence Based Interventions policy – see reference 1B.	
	1B	**Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women**	Cat 1 . Not routinely commissioned	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **2020/21 National Tariff Payment System – a consultation notice**https://improvement.nhs.uk/documents/6257/2021_NTPS_statutory_consultation_notice.pdf (page 132)	exceptionality can be applied for via a clinical letter to the IFR panel.
Haematology	2EE	**Blood Transfusion**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy P.26** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE secondary care

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Ophthalmology		**Meibomian cyst (Chalazia) removal**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
	LEBI	**Blepharoplasty**	Local Evidence Based interventions – criteria led. Referral should only be made for the following indication: • To relieve symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue. **OR** • Following skin grafting for eyelid reconstruction **OR** • Following surgery for ptosis For all other individuals, the following criteria apply: • Documented patient complaints of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking	**For Local Evidence Base and Criteria See Appendix 2** **Minhas A, Ronoh J., Badrinath P., 2008.** "Upper Eyelid Blepharoplasty for the Treatment of Functional Problems: A Brief to the Suffolk PCT Clinical Priorities Group". Suffolk PCT. **Hacker H.D. and Hollsten D.A, 1992.** "Investigation of automated perimetry in the evaluation of patients for upper lid blepharoplasty". Ophthalmic, Plastic & Reconstructive Surgery 8 (4) pp. 250-255. **Purewal B.K. and Bosniak S., 2005.** "Theories of upper eyelid blepharoplasty". Ophthalmology Clinics of North America 18 (2) pp 271-278. **American Academy of Ophthalmology, 1995.** "Functional Indications for Upper and Lower Eyelid Blepharoplasty". Ophthalmic Procedures Assessment American Journal of Ophthalmology 102 (4) pp. 693-695.	Refer using checklist. IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			through the eyelids or seeing the upper eye lid skin **AND** • There is redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND** Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly	**Kosmin A.S., Wishart P.K., Birch M.K.,** 1997. "Apparent glaucomatous visual field defects caused by dermatochalasis". Eye 11 pp. 682-686	
	LEBI	**Cataract Surgery**	Local Evidence Based interventions – criteria led All requests for the surgical removal of cataract(s) will **only** be supported by the CCG when the following applies: The total assessment score is 7 or above as per the cataract assessment and referral form Second eye surgery will be considered on the same basis as first eye surgery ***Exceptions*** Exceptions are applicable to first or second eye.	**For Local Evidence Base and Criteria See Appendix 2** **NICE Guidance** Cataracts in adults: management (NG77) https://www.nice.org.uk/guidance/ng77 NICE February 2014. Eye conditions pathway http://pathways.nice.org.uk/pathways/eye-conditions NICE guidance IPG 264. June 2008. https://www.nice.org.uk/guidance/ipg264 NICE guidance IPG 209.February 2007. http://guidance.nice.org.uk/IPG209 **Department of Health**. National Eye Care Plan (2004)	Refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			The only exceptions to the above referral criteria are as follows: • Anisometropia (a large refractive difference between the two eyes, on average about dioptres) which would result in poor binocular vision or disabling diplopia which may increase falls. • Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma • Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management. • Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery • Corneal disease where early cataract removal would reduce the	**The Royal College of Ophthalmologists**: Cataract Surgery guidelines (2004) **NHS Executive** Action on Cataracts; Good Practice Guidance (2000). **Evans JR, Fletcher AE, Wormald RP, Ng ES. Stirling S.** Prevalence of visual impairment in people aged 75 years and older in Britain: Results from the MRC trial of assessment and management of older people in the community. *Br J Ophthalmol* 2002; 86: 795-800	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty) • Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis) • Other glaucoma's (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography • Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes) • Post Vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia.		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			• Cataracts progress fairly rapidly following vitrectomy and are age dependent. Patients over the age of 50, especially those over 60 can have a rapid increase in the density of a cataract.		
Orthopaedics	1C	**Knee arthroscopy for patients with osteoarthritis**	Cat 1 . Not routinely commissioned	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **2020/21 National Tariff Payment System – a consultation notice**https://improvement.nhs.uk/documents/6257/2021_NTPS_statutory_consultation_notice.pdf (page 132)	exceptionality can be applied for via a clinical letter to the IFR panel.
	1D	**Injection for non-specific low back pain**	Cat 1 . Not routinely commissioned	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **2020/21 National Tariff Payment System – a consultation notice**https://improvement.nhs.uk/documents/6257/2021_NTPS_statutory_consultation_notice.pdf (page 132)	exceptionality can be applied for via a clinical letter to the IFR panel.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics	1L	**Arthroscopic shoulder decompression for sub-acromial shoulder pain**	**See Appendix 2 for additional local guidance** The CCG will **only** fund Arthroscopic shoulder decompression for sub-acromial shoulder pain as a standalone procedure when the following criteria are all met: • Patient has had symptoms for at least 3 months from the start of treatment **AND** • Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) **AND**	**British Elbow & Shoulder Society (BESS), British Orthopaedic Association (BOA), Royal College of Surgeons for England (RCSEng)** Commissioning Guide: Subacromial Shoulder Pain https://www.boa.ac.uk/wp-content/uploads/2014/08/Subacromial-Shoulder-Commissioning-Guide_final.pdf **Evidence Based Interventions** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf Commissioners have elected to follow the existing local policy for Arthroscopic shoulder decompression for sub-acromial shoulder pain.	Evidence Based Intervention – refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics			• Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks **AND** • Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management **AND** • Referral is at least 8 weeks following steroid injection **AND** Patient confirms they wish to have surgery	Although the national policy mentions that non-operative management is effective, the existing SY&B policy is clearer on the clinical criteria for conservative treatments.	
	1M	**Carpal tunnel release**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
	1N	**Dupuytren's surgery**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
	1O	**Ganglion surgery**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
	1P	**Trigger finger release**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **Cost of Immediate Surgery Versus Non-operative Treatment for Trigger Finger in Diabetic Patients** https://www.ncbi.nlm.nih.gov/pubmed/27671766	Evidence Based Intervention – refer using checklist. IFR for exceptionality
Orthopaedics	2E	**Knee arthroscopy for meniscal tears**	National evidence based interventions	National Based Interventions policy: P.55 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary care checklist
	2J	**Lumbar Discectomy - Spinal surgery for a slipped disc**		**National Evidence Based Interventions Policy P.29** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist
	2K	**Lumbar Radiofrequency facet joint denervation**	Not routinely commissioned	National Evidence Based Interventions Policy P.31 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	exceptionality can be applied for via a clinical letter to the IFR panel.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics	2S	**Low back pain imaging**	Not routinely commissioned	**National Evidence Based Interventions Policy. P. 50** **EBI_list2_guidance_150321.pdf (aomrc.org.uk)** **For further information please see the following NICE guidance:** **— Low back pain and sciatica in over 16s: assessment and management (November 2016)** **https://www.nice.org.uk/guidance/ng59** **— Low back pain and sciatica in over 16s: assessment and management (November 2016) - Quality statement 2: Referrals for imaging** **https://www.nice.org.uk/guidance/qs155/chapter/Quality-statement-2-Referralsfor-imaging** **— National Pathway of Care for Low Back and Radicular Pain** **https://www.nice.org.uk/guidance/ng59/resources/endorsed-resource-nationalpathway-of-care-for-low-back-and-radicular-pain-4486348909.**	ICE (not routine investigation) – not routinely commissioned
	2T	**Knee MRI when symptoms are**	National Based Interventions policy	**National Evidence Based Interventions Policy P.53** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
		suggestive of osteoarthritis			
	2U	**Knee MRI for suspected meniscal tears**	National Based Interventions policy	**National Evidence Based Interventions Policy P.18** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary care checklist
Orthopaedics	2V	**Vertebral augmentation (vertebroplasty or Kyphoplasty) for painful osteoporotic vertebral fractures**	National Based Interventions policy	**National Evidence Based Interventions Policy P.57** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist
	2W	**Imaging for shoulder pain**	National Based Interventions policy	National Evidence Based Interventions Policy P. 60 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
	2X	**MRI scan of the hip for arthritis**	National Based Interventions policy	National Evidence Based Interventions Policy P. 63 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE and IFR
	2Y	**Surgery to fuse the bones in the back for back pain - Fusion surgery for mechanical axial low back pain**	Cat 1 Not routinely commissioned	National Evidence Based Interventions Policy P.65 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	exceptionality can be applied for via a clinical letter to the IFR panel

	LEBI	**Hallux Valgus**	Local Evidence Based interventions – criteria led This procedure is **not** funded for cosmetic reasons or for asymptomatic or mild symptomatic hallux valgus. • Surgery for hallux valgus will be funded if the following criteria are met and evidenced in clinic letters: • ulcer development over the site of the bunion or the sole of the foot **OR** • evidence of severe deformity (over or under riding toes) **OR** • Significant and persistent pain when walking **AND** conservative measures tried for at least six months (e.g. bunion pads / insoles / altered footwear) have failed to provide do not provide symptomatic relief in sensible shoes **OR** • Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees.	**For Local Evidence Base and Criteria See Appendix 2** **NICE** http://pathways.nice.org.uk/pathways/musculoskeletal-conditions (accessed 2016) **National Institute of Health.** Consensus development program. Dec 2003 https://consensus.nih.gov/2003/2003totalkneereplacement117html.htm (accessed 2016) The musculoskeletal services framework – A joint responsibility: doing it differently. **Department of Health**. 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf **Namba, R., Paxton, L., Fithian, D., and Stone, M.** Obesity and perioperative morbidity in total hip and total knee arthroplasty patients. J Arthroplasty 20(7) Supplement 3 (2005), 46-50. **Hawkeswood MD, J.,Reebye MD, R.** Evidence-based guidelines for the nonpharmacological treatment of osteoarthritis of the hip and knee. Issue: BCMJ, Vol. 52, No. 8, October 2010, page(s) 399-403 Articles. **College of General Practitioners.** 'Guideline for the non-surgical management of hip and knee osteoarthritis. July 2009.InterQualR. Total Joint Replacement Hip Procedures criteria. 2013.	Refer using checklist. IFR for exceptionality.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
				NICE. TA44 Metal on Metal Hip Resurfacing. 04 January 2013. https://www.nice.org.uk/guidance/TA2/documents/appendix-b-proposal-paper-presented-to-the-institutes-guidance-executive2 **NHS England.** Interim Clinical Commissioning Policy: Hip Resurfacing. November 2013 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC019.pdf **Kandala NB, Connock M, Pulikottil-Jacob R, Sutcliffe P, Crowther MJ, Grove A,Mistry H Clarke A.** Setting benchmark revision rates for total hip replacement: analysis of registry evidence. BMJ 2015;350:h756 doi: 10.1136/bmj.h756 (Published 9 March 2015)	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics	LEBI	**Hip/Knee Replacement for osteoarthritis**	Local Evidence Based interventions – criteria led Patient's clinical condition must be clearly documented during a clinical encounter prior to surgical decision and documentation must include dates and description of measures: (If more than one joint replacement is being considered **EACH** surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required. Patients **DO NOT** require referral back to the GP for re referral) The CCG will **only** fund hip/knee replacement for osteoarthritis when conservative measures have failed (listed below) or its successor **AND** the following criteria have been met: • Referral to the Hip or Knee Pathway **AND** • Patient has a BMI of less than 35** (Patients with BMI>35 should be referred for weight management interventions for a minimum of 6 months. If the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process **AND** • Intense to severe persistent pain (defined in table one provided in the checklist and documentation to support is required) which leads to severe functional limitations (defined in table two provided in the checklist and documentation to support is required), ***OR*** • Moderate to severe functional limitation (defined in table two and documentation to support is required) affecting the patients quality of life despite 6 months of conservative measures* including referral to the local hip pathway or its successor.		Evidence Based Intervention – refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics			***Exceptions include:*** • Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. • Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure. • Rapid onset of severe hip pain ****Conservative measures:*** • Patient education such as elimination of damaging influence on hips/knees, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment. Documentation of this is required. **AND** • Physiotherapy **AND** • Oral NSAIDS a minimum of 3 weeks and paracetamol based analgesics. Documentation of dates and medication types is required. ****** Not applicable to Barnsley patients due to Get Fit First Programme.		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			The requirement for "Patient has a BMI of less than 35" is replaced with "Patient meets Get Fit First criteria" i.e. • Patient has a BMI of less than 30 *OR* • Patient has engaged with Get Fit First health improvement and reached target weight (lost 10% from starting weight) *OR* • If the patients completes Get Fit First health improvement but fails to achieve necessary weight loss then referral is at the discretion of the clinicians involved, however further weight will likely be advised and he surgeon may not operate due to increased risk. ** BMI not applicable to Sheffield patients <u>** Not applicable to Rotherham Patients due to the Fitter Better Sooner programme</u> • Evidence of smoking abstinence will be required prior to referral for surgery. Patients who stop smoking can be referred after 12 weeks. Patients who do not stop smoking will be referred for surgery after 9 months from initial consultation and advised to abstain from smoking for a minimum of 2 days prior to surgical intervention. This will allow a period of health improvement. • Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 9 months from initial consultation (subject to clinical opinion). <u>Note:</u> For Hip / Knee Replacement the previous BMI requirement (35) is replaced with 'Patient meets Fitter Better Sooner criteria'		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Paediatrics	2Z	**Helmet therapy in the treatment of positional plagiocephaly in children**	Cat 1 Not routinely commissioned	**National Evidence Based Interventions Policy P.66** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).
Pain Clinic	LEBI	**Acupuncture**	Not Routinely Commissioned except for chronic tension type headaches and migraine **Doncaster/Bassetlaw patients** – Acupuncture for headaches and migraine for patients who require a repeat 10 week treatment programme must be re-referred by the GP if the patient still benefits from acupuncture.	NICE Guideline NG59 https://www.nice.org.uk/guidance/ng59 NICE CKS – Migraine https://cks.nice.org.uk/migraine CG 150 Headaches in over 12s – Diagnosis and Management https://www.nice.org.uk/guidance/cg150/chapter/recommendations	Refer through IFR for exceptionality

Plastics	1E and LEBI	**Breast reduction / asymmetry and Gynaecomastia**	See 'Breast Reduction' and 'Gynaecomastia' section of Specialist Plastics Policy Summarised in Appendix 3	SY&B Commissioners have elected to follow the existing local Specialist Plastics Policy for these interventions. <u>Breast Reduction</u> Referrals for breast reduction under the national criteria would require the clinician to accurately assess the weight of breast tissue to be removed [500gms or 4 cup sizes]. Additional clinical input is required hence the recommendation to use IFR. The local policy requires a minimum G cup which has been professionally measured to ensure equity. For cases that are borderline medical photographs are requested. <u>Asymmetrical Breasts</u> For asymmetrical breasts the Evidence Based Interventions guidance states a difference of 150-200g is required whereas the local policy stipulates a difference of two cup sizes with a professional measurement. <u>Gynaecomastia</u> The national Evidence Based Interventions guidance states that surgery to correct gynaecomastia will only be commissioned for men with a history of prostate cancer. SY&B Commissioners have elected to follow the existing local Specialist Plastics policy for gynaecomastia which provides more comprehensive guidance on where this corrective intervention may be funded.	Prior Approval via IFR. Clinical Letter and questionnaire The IFR panel will provide clinical oversight on the management of these policies. Refer through IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Urology	2G	**Surgical removal of kidney stones**	National Based Interventions policy	**National Evidence Based Interventions Policy P.23** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist
	2H	**Cystoscopy for men with un-complicated lower urinary tract symptoms**	National Based Interventions policy	**National Evidence Based Interventions Policy P.25** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Primary Care checklist
	2I	**Surgical intervention for benign prostatic hyperplasia**	National Based Interventions policy	**National Evidence Based Interventions Policy P.26** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist
	2CC	**Prostate- specific antigen (PSA) testing**	National Based Interventions policy	**National Evidence Based Interventions Policy P.72** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
	LEBI	**Male Circumcision**	Local Evidence Based interventions – criteria led Circumcision will **only** be commissioned for the following indications as confirmed by an appropriate clinician: • Phimosis (inability to retract the foreskin due to a narrow prepucial ring) • Recurrent paraphimosis (inability to pull forward a retracted foreskin)	**For Local Evidence Base and Criteria See Appendix 2** **NHS Choices.** Circumcision in adults: http://www.nhs.uk/conditions/Circumcision/Pages/Introduction.aspx (Accessed 16 January 2017) **Royal College of Surgeons**. Commissioning guide: Foreskin conditions. 2013. Available from: http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions	Refer using checklist. IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			• Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin) • Balanoposthitis (recurrent bacterial infection of the prepuce) • Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	**Moreno G, Corbalán J, Peñaloza B, Pantoja T**. Topical corticosteroids for treating phimosis in boys. Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD008973. DOI: 10.1002/14651858.CD008973.pub2 **Liu, Yang, Chen et al**. Is steroids therapy effective in treating phimosis? A meta-analysis. Int Urol Nephrol. 2016 Mar; 48(3):335-42. doi: 10.1007/s11255-015-1184-9 **Zhu, Jia, Dai et al.** Relationship between circumcision and human papillomavirus infection: a systemic review and meta-analysis. Asian J Androl. 2016 March. http://www.ajandrology.com/article.asp?issn=1008-682X;year=2017;volume=19;issue=1;spage=125;epage=131;aulast=Zhu **Singh-Grewal D,Macdessi J, Craig J.** Circumcision for the prevention of urinary tract infection in boys: a systematic review of randomised trials and observational studies. Arch Dis Child. 2005 Aug;90(8):853-8 **Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al.** Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. The Lancet. 2007;369 (9562): 643–56	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
	LEBI	**Vasectomy under General Anaesthetic**	Not Routinely Commissioned Needle phobia is no longer an exception for this procedure	**NHS Choices** https://www.nhs.uk/conditions/contraception/vasectomy-male-sterilisation/	Refer to local service in community. Refer through IFR for exceptionality
Vascular	1Q	**Varicose vein surgery**	National Evidence Based Interventions Policy In addition the SYB Policy requires patients to have a BMI of 30 or less. (The BMI criteria will not apply for Sheffield patients). Note: If a patients BMI remains above 30, completion of Get Fit First 6 month health improvement does not negate this criterion for Barnsley patients. For Rotherham patient the Fitter Better Sooner applies. Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 9 months from initial consultation (subject to clinical opinion).	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **National Institute for Health and Care Excellence** (July 2013) Varicose veins: diagnosis and management [CG 168] London: National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/cg168/evidence/full-guideline-pdf-191485261 NICE clinical guidance 168 notes that a raised BMI is identified as factor associated with increased risk of progression of varicose veins and notes that the surgical outcome with increased BMI is worse (there is a higher risk of reoccurrence).	Evidence Based Intervention – refer using checklist. IFR for exceptionality Sheffield CCG excluded from the BMI requirement for this procedure.

15. Plastics and Fertility Procedures

15.1 Fertility

Speciality	Procedure	Commissioning Position	Evidence Base	Process
Obstetrics & Gynaecology	Reversal of Female Sterilisation	**Not Routinely Commissioned**	**National supporting evidence** NHS England Interim Commissioning Policy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC028.pdf **Faculty of Sexual and Reproductive Healthcare (FSRH)** Clinical Guidance- Male and Female Sterilisation - Summary of Recommendations Clinical Effectiveness Unit September 2014 **http://www.fsrh.org/pdfs/MaleFemaleSterilisationSummary.pdf**	Refer through IFR for exceptionality
Obstetrics & Gynaecology	In-vitro fertilisation (IVF)/ Assisted conception	IVF is commissioned in line with the Y&H Fertility policy	Y&H Access to Infertility Treatment Policy Link for Rotherham - Access to Infertility Treatment (rotherhamccg.nhs.uk) Link for Sheffield Link for Barnsley Link for Doncasterhttps://www.doncasterccg.nhs.uk/wp-content/uploads/2020/07/Access-to-infertility-treatment-V11.1-July-2020.pdf Link for Bassetlaw http://platform-ccg-live-eu-2.s3-eu-west-1.amazonaws.com/attachments/9223/original/BCCG_COM_001_Access_to_infertility_treatment__V12_FINALJune2021_-_BCCG.pdf?AWSAccessKeyId=AKIAWW5JKDXVJRBFNM4V&Expires=1623933002&Signature=LbDhWD4jcdjIF7UNQki5O2em4Qk%3D	Policy applied in secondary care. Referral through IFR for exceptionality
Urology	Reversal of Male Sterilisation	**Not Routinely Commissioned** Reversal of sterilisation is not routinely commissioned. Informed consent for sterilisation requires that patients have	**National supporting evidence** NHS England Interim Commissioning Policy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC028.pdf **Faculty of Sexual and Reproductive Healthcare (FSRH)** Clinical Guidance- Male and Female Sterilisation - Summary of Recommendations Clinical Effectiveness Unit September 2014 **http://www.fsrh.org/pdfs/MaleFemaleSterilisationSummary.pdf**	Refer through IFR for exceptionality

Speciality	Procedure	Commissioning Position	Evidence Base	Process
		understood the irreversible nature of the procedure. The clinician may still submit an application to sheccg.sybifr@nhs.net (safehaven) if exceptionality can be demonstrated.		

15.2 Specialist Plastic Surgery Procedures

Speciality	Procedure	Commissioning Position	Process
Plastic and Cosmetic surgery	1. Abdominoplasty	**Not Routinely Commissioned** **See Appendix 3 for information on when cases may be considered on an exceptional basis and evidence base.**	Refer through IFR for exceptionality
	2. Breast Surgery 2.1 Breast Augmentation 2.2 Breast Reduction 2.3 Breast Asymmetry 2.4 Breast Reduction for gynaecomastia 2.5 Breast lift mastopexy 2.6 Correction of nipple inversion		
	3.Hair 3.1 Hair removal 3.2 Correction of male pattern baldness 3.3 Hair transplantation		
	4. Acne scarring		
	5. Buttock, thigh and arm lift surgery		
	6. Congenital vascular abnormalities		

Speciality	Procedure	Commissioning Position	Process
	7. Correction of Prominent Ears		
	8. Facelift, browlift & Botulinum toxin		
	9. Labioplasty, Vaginoplasty and Hymen Reconstruction		
	10. Liposuction		
	11. Rhinoplasty		
	12. Rhinophyma		
	13. Surgical scars		
	14. Thread vein/ Telangiectasia		
	15. Tattoo removal		
	16. Surgical Repair of Torn Ear Lobes		

16. Monitoring and payment

Zero payment or Category 1 Interventions without IFRs

These procedures are not routinely commissioned. Only activity that is approved by IFR will be paid for. Any activity that does not meet this threshold will be reimbursed at £0 (zero tariff) to reflect changes to the NHS Standard Contract and National Tariff Payment System from 1 April 2019.

Category 2 Interventions and Local Evidence Based Interventions

These interventions are only commissioned when specific criteria are met. CCGs will audit adherence to Evidence Based Interventions. Where there is no evidence that the patient meets the criteria for treatment, CCGs will not pay for the patient's treatment. Service Condition 29.22 of the NHS Standard Contract makes clear that the commissioner is under no obligation to pay for activity which has been undertaken by the provider in contravention of agreed prior approval schemes.

CCGs will monitor activity and finance levels on a monthly basis through Contract Performance Meetings. A baseline will be established and activity monitored against the procedure and diagnostic codes listed in Appendix 5

Part 4
Appendices

Appendix 1 - Evidence Based Threshold Checklists

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Removal of Benign Skin Lesions

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund management of benign skin lesions when **one or more** of the following criteria are met*:

Where it is safe to do so, every attempt should be made to manage benign skin lesions in primary care/community setting *provided removal would not be purely cosmetic.*	Delete as appropriate	
Diagnostic uncertainty exists and there is suspicion of malignancy ***(please refer as appropriate).***	Yes	No
The lesion is painful or impairs function and warrants removal, but it would be unsafe to do so in primary care/community setting, for example because of large size (>10mm), location (e.g. face or breast) or bleeding risk. ***Removal would not be purely cosmetic.***	Yes	No
Viral warts in immunosuppressed patients.	Yes	No
Patient scores >20 in Dermatology Life Quality Index** ***administered during a consultation with the GP or other healthcare professional.***	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information. If patient meets the above criteria then prior approval is not required.*

***See* http://www.dermatology.org.uk/quality/dlqi/quality-dlqi.html *for information on the use of the Dermatology Life Quality Index.*

This policy does not apply to treatment of benign skin lesions in the perianal area.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Grommets for Otitis Media with Effusion in Children

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund Grommets for Otitis Media with Effusion in children (when the following criteria are met:

In ordinary circumstances*, referral should not be considered unless the patient meets one or more of the following criteria when presenting in a Primary Care setting:	**Delete as appropriate**	
Recurrent acute otitis media - 5 or more recorded episodes in the preceding 12 month period.	Yes	No
Suspected hearing loss at home or at school / nursery,	Yes	No
Speech delay, poor educational progress due to the hearing loss, following 3 months of watchful waiting	Yes	No
Abnormal appearance of tympanic membrane	Yes	No
In ordinary circumstances*, procedure should not be considered unless the patient meets one or more of the following criteria when presenting in a Secondary Care setting:	**Delete as appropriate**	
Persistent hearing loss for at least three months (in any setting) with hearing levels of:25dBA or worse in both ears on pure tone audiometry or • 25dBA or worse or 35dHL or worse on free field audiometry testing and • Type B or C2 tympanometry	Yes	No
Suspected underlying sensorineural hearing loss	Yes	No
Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk.	Yes	No
OME in the presence of a secondary disability e.g. autistic spectrum disorder, Down's Syndrome, cleft palate.	Yes	No
Persistent OME (more than three months) with fluctuating hearing but significant delay in speech, educational attainment or social skills.	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

As the presence of a second disability such as Down's syndrome or cleft palate can predispose children to OME in such children it is left to the clinician's discretion how far this policy will apply.

Tonsillectomy

INFORMATION TO ACCOMPANY AN INDIVIDUAL FUNDING REQUEST (IFR) FOR TONSILLECTOMY (CHILDREN & ADULTS)

Instructions for Use
Please send this form to the IFR panel.
PLEASE ATTACH A BRIEF REFERRAL LETTER IN SUPPORT OF YOUR REQUEST

Patient Details	
PATIENT NAME	
DATE OF BIRTH	
NHS NUMBER	
ADDRESS	
REFERRING GP	

ADDITIONAL INFORMATION: A six month period of watchful waiting is recommended prior to referral for tonsillectomy in order to establish a pattern of symptoms.

	Delete as appropriate	
Sore throats are due to acute tonsillitis	Yes	No
Episodes of sore throat are disabling and prevent normal functioning as evidence by three of the Centor criteria (tonsillar exudates, tender anterior cervical lymph nodes, history of fever [over 38], and absence of cough).	Yes	No

Please supply ALL dates of disabling episodes of tonsillitis when your patients has been seen AND treated over the past 3 years:

	Delete as appropriate	
Two or more documented episodes of quinsy (peri-tonsillar abscess)	Yes	No
Severe halitosis secondary to tonsillar crypt debris	Yes	No
A child with failure to thrive due to difficulty swallowing secondary to tonsillar hypertrophy	Yes	No
Obstructive sleep disordered breathing (see criteria below)	Yes	No

THE COMMISSIONING CRITERIA ARE DETAILED OVERLEAF

GP Signature	
Date	

Criteria for Commissioning Tonsillectomy (Children and Adults)

The CCG will **only** fund tonsillectomy when one or more of the following criteria have been met:

- Recurrent attacks of tonsillitis as defined by:
  - Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning

  AND
  - 7 or more well documented, clinically significant*, adequately treated episodes in the preceding year **OR** 5 or more such episodes in each of the preceding 2 years **OR**
    3 or more such episodes in each of the preceding 3 years

**A clinically significant episode is characterised by at least three of the following (Centor criteria):*

-Tonsillar exudate

-Tender anterior cervical lymphadenopathy or lymphadenitis

-History of fever (over 38'C)

-Absence of cough

- Two or more episodes of quinsy (peri-tonsillar abscess)
- Severe halitosis secondary to tonsillar crypt debris
- Failure to thrive (child) secondary to difficulty swallowing caused by enlarged tonsils
- Obstructive sleep disordered breathing causing severe daytime and night time symptoms

Obstructive sleep disordered breathing is defined as:

-Grade 3 or 4 tonsils AND
-Symptoms persisting for more than three months AND
-Night time symptoms- consistent snoring AND consistent wakefulness OR secondary enuresis OR witnessed apnoeas OR restlessness/excessive sweating AND
-Daytime symptoms- impaired school performance OR hyperactivity/aggression OR altered mood OR excessive tiredness

- Biopsy/removal of lesion on tonsil- notification only, prior approval not required.

National Supporting Evidence

Scottish Intercollegiate Guidelines Network
Management of sore throat and indications for tonsillectomy. A National clinical Guideline. April 2010
https://www.sign.ac.uk/assets/sign117.pdf

Evidence Based Interventions: Guidance for CCGs
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

Individual Funding Requests (IFR) should be sent to:

Alison Ball
Head of Individual Funding Requests
722 Prince of Wales Road
Sheffield S9 4EU
Safehaven Fax: 0114 3051370
Safehaven Email: sheccg.sybifr@nhs.net

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Haemorrhoidectomy

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund haemorrhoidectomy when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Recurrent third or fourth degree combined external/internal haemorrhoids with persistent pain or bleeding **OR**	Yes	No
Irreducible and large haemorrhoids with frequently reoccurring, persistent pain or bleeding **OR**	Yes	No
Failed conservative treatment (including non-operative interventions: rubber band ligation, injection sclerotherapy, infrared coagulation/photocoagulation, bipolar diathermy and direct-current electrotherapy.)	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information. . If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hysterectomy for Management of Heavy Menstrual Bleeding

Instructions for use:
To Secondary Care Clinician: Please refer to the policy for full details, and ensure there is evidence that the criteria selected are met. Complete the checklist and file for future compliance audit.

The CCG will only fund Hysterectomy when the following criteria are met:
Dilation and Curettage (D&C) is **not** routinely commissioned to either diagnose or treat heavy menstrual bleeding in line with Evidence Based Interventions Policy. Patients **WILL NOT** receive a D&C:

- As a diagnostic tool **ALONE** for heavy menstrual bleeding, **or**
- As a therapeutic treatment for heavy menstrual bleeding.

Patients **WILL** receive hysterectomy in the investigation and management of heavy menstrual bleeding only when the following criteria are met respectively for each procedure:

Please note that if a patient declines any element an application for exceptional funding must be made to the IFR team

Hysterectomy for HMB will only be funded if ALL the following criteria are met:	**Delete as appropriate**	
A levonorgestrel intrauterine system (e.g. Mirena) has been trialled for *at least 6 months* (unless declined or contraindicated) and has not successfully relieved symptoms **AND**	Yes	No
A trial of *at least 3 months each* of two other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, or not tolerated). These treatment options include: • NSAIDs Tranexamic acid • Combined oral contraceptive pill • Oral and injected progestogens **AND**	Yes	No
Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation or uterine artery embolisation (UAE) have either been ineffective or are not appropriate, or are contraindicated	Yes	No

If patient meets the above criteria then prior approval is not required. Please note that if a patient declines any element IFR must apply.

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information.

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Meibomian cyst (Chalazion)

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund surgical treatment of chalazia when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **two or more** of the following criteria*	**Delete as appropriate**	
Conservative treatment has been tried for at least 3 months **AND**	Yes	No
Interferes with vision **OR**	Yes	No
Interferes with the protection of the eye due to altered lid closure or anatomy **OR**		
Is a source of infection requiring medical attention at least twice within the last six months **OR**	Yes	No
Is a source of infection causing an abscess requiring drainage	Yes	No

** If the patient does not fulfil these criteria but the clinician feels there are exceptional circumstances please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

A meibomian cyst/chalazion that keeps coming back should be biopsied to rule out malignancy. Use the appropriate referral route for suspected malignancy in this case.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Arthroscopic Subacromial Decompression of the Shoulder (ASAD)

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund ASAD as a standalone procedure when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **ALL** of the following criteria.*	**Delete as appropriate**	
Patient has had symptoms for at least 3 months from the start of treatment **AND**	Yes	No
Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) **AND**	Yes	No
Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks **AND**	Yes	No
Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management **AND**	Yes	No
Referral is at least 8 weeks following steroid injection **AND**	Yes	No
Patient confirms they wish to have surgery	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Carpal Tunnel Syndrome Surgery.

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund Carpal Tunnel Surgery when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	Delete as appropriate	
Severe symptoms at presentation (including sensory blunting, muscle wasting, weakness on thenar abduction or symptoms that significantly interfere with daily activities)**	Yes	No
If there is no improvement in mild-moderate symptoms after 3 months conservative management which includes nocturnal splinting used for at least 8 weeks (documentation of dates and type(s) of conservative measures is required)	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information. If patient meets the above criteria then prior approval is not required.*

**This criterion includes all individuals whose symptoms are severe where six months conservative management would be detrimental to the management of the condition. Evidence should be provided to demonstrate severity of symptoms.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Dupuytren's Disease

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund correction of Dupuytren's disease when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets one of the following criteria.*	Delete as appropriate	
** 30 degrees or more fixed flexion at the metacarpophalangeal (MCPJ) joint **OR**	Yes	No
** 20 degrees or more fixed flexion at the proximal interphalangeal (PIPJ) joint **OR**	Yes	No
Severe thumb contractures which interfere with function	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required. ** Inability to flatten fingers or palm on table*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Ganglions

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund correction of Ganglion(s) when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	Delete as appropriate	
Painful seed ganglia** that persist or recur after puncture/aspiration **OR**	Yes	No
Mucoid cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint) **OR**	Yes	No
Wrist ganglia associated with neurological deficit, restricted hand function or severe pain	Yes	No
If the diagnosis is in doubt	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to The Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

*** A seed ganglia is a fluid filled swelling that appears at the base of the finger on the palm side.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Trigger Finger

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund Trigger finger correction when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets the following criteria:*	Delete as appropriate	
Failure to respond to up to two steroid injections** (one in the case of patients with diabetes mellitus) or splinting of the finger for 3-12 weeks (does not apply if the patient has had 2 previous trigger digits unsuccessfully treated with non-operative methods) **AND**	Yes	No
Loss of complete active flexion	Yes	No

*** Where injection of trigger finger is not available in primary care, please refer to MSK for this treatment*

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Varicose Vein Surgery

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

Treatment of varicose veins in secondary care is considered a low priority treatment and will only be funded by the CCG if the criteria below have been met. Treatment will NOT be funded for cosmetic reasons or in pregnancy.

Patients can be considered for surgery if they meet the following criteria:	Delete as appropriate	
Patient's BMI is 30[#] or less **AND**	Yes	No
Intractable ulceration secondary to venous stasis **OR**	Yes	No
Bleeding varicose vein or if the patient is at high risk of re-bleeding. (i.e. there has been more than one episode of minor haemorrhage or one episode of significant haemorrhage from a ruptured superficial varicosity) **OR**	Yes	No
Significant and or progressive lower limb skin changes such as Varicose eczema, or lipodermatosclerosis with moderate to severe oedema proven to be caused by chronic venous insufficiency (itching is insufficient for referral) **OR**	Yes	No
Thrombophlebitis associated with severe and persistent pain requiring analgesia and affecting activities of daily living and or instrumental activities of daily living* **OR**	Yes	No
If the patient is severely symptomatic affecting activities of daily living and or instrumental activities of daily living. - **ALL** below must apply: • Symptoms must be caused by varicosity and cannot be attributed to any other comorbidities or other disease affecting the lower limb. • There must be a documented unsuccessful six month trial of conservative management.** • Evidence that symptoms are affecting activities of daily living and/or Instrumental activities of daily living.	Yes	No

[#]This criteria does not apply to Sheffield CCG patients.
After completion of the Get Fit First health improvement period, Barnsley patients must achieve a BMI below 30 in order to qualify for treatment.
After completion of the Fitter Better Sooner health improvement period, Rotherham patients must achieve a BMI below 30 in order to qualify for treatment.

*Activities of daily living include: functional mobility, eating, bathing and personal care. They can be measured using the Barthel activities of daily living index. Instrumental activities of daily living include more complex tasks such as care of others, community mobility, health management and meal preparation.
** Conservative management should include advice on walking and exercise, avoidance of activities that exacerbate symptoms, leg elevation whenever sitting and weight loss and compression stockings if appropriate.

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to CCG's Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Grommets in Adults

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund Grommets for Adults when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets one or more of the following criteria.*	**Delete as appropriate**	
Persistent hearing loss for at least 3 months with hearing levels of 25dB or worse on pure tone audiometry **OR**	Yes	No
Recurrent acute otitis media – 5 or more episodes in the preceding 12 month period **or**	Yes	No
Eustachian tube dysfunction causing pain **OR**	Yes	No
Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk **OR**	Yes	No
As a conduit for drug delivery direct to the middle ear **OR**	Yes	No
In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician **or**	Yes	No
Part of a more extensive procedure at Consultant's discretion such as tympanoplasty, acute otitis media with facial palsy	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Treatment of benign perianal skin lesions in secondary care

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund surgical treatment of benign skin lesions when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
There is clinical uncertainty about the benign nature of the skin lesion	Yes	No
Viral warts in immunocompromised patients where underlying malignancy may be masked	Yes	No
Recommended by GU Med when conservative treatment has failed	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Management of Gall bladder disease including **mild and asymptomatic/incidental gallstones

Instructions for use:
Please refer to policy for full details.
Secondary Care to complete the checklist and file for future compliance audit.

The CCG will **only** provide funding for cholecystectomy in **mild (see policy) or asymptomatic gallstones if **one or more** of the following criteria are met:	**Delete as appropriate**	
*High risk of gall bladder cancer, e.g. gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer).	Yes	No
Transplant recipient (pre or post-transplant).	Yes	No
Diagnosis of chronic haemolytic syndrome by a secondary care specialist.	Yes	No
Increased risk of complications from gallstones, e.g. presence of stones in the common bile ductstones smaller than 3mm with a patent cystic duct, presence of multiple stones.	Yes	No
Acalculus cholecystitis diagnosed by a secondary care specialist.	Yes	No

* *(Annual USS for smaller asymptomatic polyps)*

**Barnsley and Rotherham CCG patients who are asymptomatic will not be funded for cholecystectomy. Patients will be funded after one episode of mild pain'

The CCG will continue to fund cholecystectomy for patients with moderate to severely symptomatic gallstones, and for acute cholecystitis or mild gallstone pancreatitis

Patient has moderate or severely symptomatic gallstones and agrees to surgery	Yes	No
*For a patient admitted to hospital with acute cholecystitis or mild gallstone pancreatitis, was index laparoscopic cholecystectomy performed within that admission?		

*This guidance may not be applicable in patients with severe acute pancreatitis

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.

If patient meets the above criteria then prior approval is not required.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgical Repair of Hernias

Instructions for use:
Please refer to policy for full details. (This policy only applies to patients aged over 16 years). Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

PATIENTS WITH DIVARICATION OF THE RECTI SHOULD NOT BE REFERRED FOR SURGICAL OPINION

Suspected groin hernias in women should be urgent referrals (adults over 19 years)

The CCG will only fund ***inguinal*** hernia surgery when the following criteria are met:

In ordinary circumstances, referral/treatment should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Symptomatic hernias i.e. those which limit work or activities of daily living **OR**	Yes	No
Hernias that are difficult or impossible to reduce **OR**	Yes	No
Inguino-scrotal hernias **OR**	Yes	No
An increase in the size of the hernia month on month (please use your clinical discretion when referring/surgical repair of these patients)	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

Please note that for asymptomatic or minimally symptomatic inguinal hernias, the CCG advocates a watchful waiting approach (informed consent regarding the potential risks of developing hernia complications e.g. incarceration, strangulation, or bowel obstruction). Patients should also be advised regarding weight loss as appropriate.

The CCG will only fund ***umbilical, para umbilical and midline ventral*** hernia surgery when the following criteria are met:

In ordinary circumstances, referral/treatment should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Pain or discomfort interfering with activities of daily living **OR**	Yes	No
An increase in the size of the hernia month on month **OR**	Yes	No
To avoid strangulation and incarceration of bowel where hernia is ≥ 2cm	Yes	No

The CCG will only fund ***Incisional*** hernia surgery when the following criteria are met:

Pain or discomfort interfering with activities of daily living	Yes	No

All suspected femoral hernias must be referred to secondary care due to the increased risk of incarceration/ strangulation	Yes	No

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Upper Eyelid Blepharoplasty

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund blepharoplasty when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria*	**Delete as appropriate**	
Does the patient complain of symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue?	Yes	No
Did the patient develop symptoms following skin grafting for eyelid reconstruction?	Yes	No
Did the patient develop symptoms following surgery for ptosis?	Yes	No

** If the patient does not fulfil these criteria but the clinician feels there are exceptional circumstances please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

If the above criteria are not met, does the patient meet ALL of the following exceptions:–

Is there documentation that the patient complains of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin **AND**	Yes	No
Is there redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND**	Yes	No
Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly	Yes	No

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Cataract Surgery
Instructions for use:

First Eye Surgery: **Please complete Part 1 and 2.**
Second Eye Surgery: Please complete Part 1 and 3.
Where a patient has been referred outside of the Cataract LES or locally commissioned service, the receiving clinician must ensure that the patient meets the Clinical Threshold. (Complete the checklist and file for future compliance audit).

The CCG will only fund Cataract Surgery, when the following criteria are met:

Part 1 - Assessment

VA Scores* VA 6/6 = 0 VA 6/9 = 1 VA 6/12 = 2 VA 6/18 = 7		**SPH**	**CYL**	**AXS**	**VA**	**Dominant Eye**	**Score**	
	R							**VA Score**
	L							

Lifestyle Questions to ask patient*	**Not at all**	**Slightly**	**Moderately**	**Very Much**
Is the patient's quality of life affected by vision difficulties (*e.g. car driving, watching TV, doing hobbies, etc?)*				
Is the patient's social functioning affected by vision difficulties (*e.g. crossing roads, recognising people, recognising coins etc?)*				

*These questions are designed to elicit the information from pts as to the effect on their lifestyle. The clinician will use the responses to weight the scoring below

Circle Score	**Yes**	**No**
Any difficulties for patient with mobility *(including aspect of travel, e.g. driving, using public transport)*?	2	0
Is the patient affected by glare in sunlight or night (*car headlights)*?	2	0
Is the patient's vision affecting their ability to carry out daily tasks?	2	0
Other (please tick as appropriate)	**Yes**	**No**
Does the patient have a learning difficulty?		
Is the patient receiving prescribed medication ? If yes please specify		
Please circle if you consider the patient will require a General (GA) or Local (LA) Anaesthetic?	GA	LA

Part 2 - First Eye Cataract Surgery

FIRST EYE TOTAL ASSESSMENT SCORE (*VA AND LIFESTYLE SCORE)*

NB: ***THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR FIRST EYE SURGERY OR THE PATIENT MEETS ONE THE EXCEPTIONS (PLEASE DOCUMENT IN PART 4)***

The patient meets the Clinical Threshold for first eye cataract surgery	**Yes**	**No**

Part 3 - Second Eye Cataract Surgery

Complete Part 1 for Second Eye

SECOND EYE TOTAL ASSESSMENT SCORE (VA AND LIFESTYLE SCORE)

NB: ***THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR SECOND EYE SURGERY OR THE PATIENT MEETS ONE THE EXCEPTIONS (PLEASE DOCUMENT IN PART 4)***

The patient meets the Clinical Threshold for second eye cataract surgery.	**Yes**	**No**

Part 4 - Exceptions

Exceptions are applicable to first or second eye.

The only exceptions to the referral criteria are as follows:	Delete as appropriate	
Anisometropia (a large refractive difference between the two eyes, on average about 3 dioptres), which would result in poor binocular vision or disabling diplopia which may increase the risk of falls.	Yes	No
Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma	Yes	No
Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management.	Yes	No
Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery	Yes	No
Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)	Yes	No
Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)	Yes	No
Other glaucoma's (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography	Yes	No
Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes)	Yes	No
Post vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia.	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.

*Snellen / Logmar Conversion Chart:

Snellen	Logmar
6/6	0.0
6/9	0.10 – 0.20
6/12	0.20 – 0.30
6/18	0.40 – 0.50
6/24	0.50 – 0.70
6/36	0.70 – 0.90
6/60	1.00

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hallux Valgus Surgery

Instructions for use:

Please refer to policy for full details.

Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund hallux valgus surgery when the following criteria are met:

This procedure is **not** funded for cosmetic reasons or for asymptomatic or mild symptomatic hallux valgus.

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	**Delete as appropriate**	
Ulcer development over the site of the bunion or the sole of the foot **OR**	Yes	No
Evidence of severe deformity (over or under riding toes) **OR**	Yes	No
Significant and persistent pain when walking **AND** conservative measures (e.g. bunion pads / insoles / altered footwear) have failed to provider symptomatic relief in sensible shoes **OR**	Yes	No
Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hip Replacement

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit

The CCG will **only** fund hip replacement for osteoarthritis if the following criteria have been met:	**Delete as appropriate**	
Referral to the Hip Pathway **AND**	Yes	No
Patient has a BMI of less than 35. (Patients with BMI>35 should be referred for weight management interventions for a minimum of 6 months. If the BMI remains over 35 then an IFR referral could be considered**.) **AND EITHER**	Yes	No
Intense to severe persistent pain (defined in table one and documentation to support is required) which leads to severe functional limitations (defined in table two and documentation to support is required), **OR**	Yes	No
Moderate to severe functional limitation (defined in table two and documentation to support is required) affecting the patients quality of life despite 6 months of conservative measures*	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to The CCG's Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.

*Conservative measures = oral NSAIDs, physiotherapy or referral to the Hip Referral Pathway, and paracetamol based analgesics and patient education (e.g. activity / lifestyle modification). Documentation of dates and types of conservative measures required to be included with this form.

** Not applicable to Barnsley patients due to Get Fit First Programme
** Not applicable to Rotherham patients due to Fitter Better Sooner Programme

Table 1: Classification of pain level

Pain level	
Slight	Sporadic pain.(May be daily but comes and goes 25% or less of the day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects

Moderate	Occasional pain.(May be daily and occurs 50-75% of the day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense / Severe	Pain of almost continuous nature.(Occurs 75-100% of the day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour or pain when resting Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs or narcotics for treatment to take effect or no response Requires the use of support systems (walking stick, crutches).

Table 2: Functional Limitations

Minor	Functional capacity adequate to conduct normal activities and self-care Walking capacity of more than one hour No aids needed
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care Walking capacity of between half and one hour Aids such as a cane are needed occasionally
Severe	Largely or wholly incapacitated Walking capacity of less than half hour Cannot move around without aids such as a cane, a walker or a wheelchair. Help of a carer is required.

If the above criteria are not met, does the patient meet the following exceptions:–

Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. (Refer through IFR)	Yes	No
Patients whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.(Refer through IFR)	Yes	No
Rapid onset of severe hip pain	Yes	No

Patients with co-morbidities should be optimised prior to referral for possible surgery

Diabetes	Hypertension	Anaemia	Sleep Apnoea
HbA1c ≤ 70 nmol/ml	**BP ≤ 160/100 Aim for 140/85 non Diabetic Aim for 140/80 Diabetic**	**Hb > 13 in men Hb > 12 in women**	**Referred for Sleep Studies with STOP BANG Score ≥ 5**

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Knee replacement

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

**Fitter better sooner programme applies for Rotherham patients. See page 20 of CFO policy

The CCG will only fund knee replacement for osteoarthritis when the following criteria have been met	**Delete as appropriate**	
Referral has been made to the Knee Pathway **AND**	Yes	No
Patient has a BMI of less than 35** (Patients with BMI>35 should be referred for weight management interventions for a minimum of 6 months. If the BMI remains over 35 then an IFR referral could be considered**.) **AND**	Yes	No
Osteoarthritis of the knee causes persistent, severe pain as defined in table 1 **AND**	Yes	No
Pain from osteoarthritis of the knee leads to severe loss of functional ability and reduction in quality of life as defined in table 2 **AND**	Yes	No
Symptoms have not adequately responded to 6 months of conservative measures* OR conservative measures are contraindicated. Documentation of dates and types of measures is required.	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further details. If patient meets the above criteria then prior approval is not required.

* Conservative measures =, oral NSAIDs, physiotherapy or referral to the Knee Referral Pathway and paracetamol based analgesics, intra-articular corticosteroid injections and patient education (e.g. activity / lifestyle modification). See policy for further details.
** Not applicable to Barnsley patients due to Get Fit First Programme
** Not applicable to Rotherham patients due to Fitter Better Sooner Programme

Table 1: Classification of pain level

Pain level	
Slight	Sporadic pain.(May be daily but comes and goes 25% or less of the day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects

Moderate	Occasional pain.(May be daily and occurs 50-75% of the day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense / Severe	Pain of almost continuous nature.(Occurs 75-100% of the day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour or pain when resting Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs or narcotics for treatment to take effect or no response Requires the use of support systems (walking stick, crutches).

Table 2: Functional Limitations

Minor	Functional capacity adequate to conduct normal activities and self-care Walking capacity of more than one hour No aids needed
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care Walking capacity of between half and one hour Aids such as a cane are needed occasionally
Severe	Largely or wholly incapacitated Walking capacity of less than half hour Cannot move around without aids such as a cane, a walker or a wheelchair. Help of a carer is required.

If the above criteria are not met, does the patient meet the following exceptions:–

Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. (Refer through IFR)	Yes	No
Patients whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure. (Refer through IFR)	Yes	No

Patients with co-morbidities should be optimised prior to referral for possible surgery

Diabetes	Hypertension	Anaemia	Sleep Apnoea
HbA1c ≤ 70 nmol/ml	**BP ≤ 160/100 Aim for 140/85 non Diabetic Aim for 140/80 Diabetic**	**Hb > 13 in men Hb > 12 in women**	**Referred for Sleep Studies with STOP BANG Score ≥ 5**

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgery for Ingrown Toenails

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund surgery for ingrown when the following criteria are met:

*In ordinary circumstances**, referral should not be considered unless the patient meets **one** of the following criteria.*	**Delete as appropriate**	
Patient has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed.	Yes	No
Patient has infection and/or recurrent inflammation due to ingrown toenail **AND** has high medical risk*.	Yes	No

**Medical risk is determined by the referring clinician - including, but not limited to, vascular disease, neurological disease or diabetes which are categorised as having high medical need due to the risk of neuropathic complications.*

***If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Male Circumcision

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS /
Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund male circumcision when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Phimosis (inability to retract the foreskin due to a narrow prepucial ring) or recurrent paraphimosis (inability to pull forward a retracted foreskin)	Yes	No
Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin)	Yes	No
Balanoposthitis (recurrent bacterial infection of the prepuce).	Yes	No
Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

This policy does not apply to:

- Penile malignancy. Use the 2ww cancer referral pathway
- Traumatic injury where the foreskin cannot be salvaged

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Upper GI Endoscopy

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS

Secondary Care complete the checklist below and file for future compliance audit.

The CCG will only fund upper GI Endoscopy when the following criteria are met*:

For the investigation of symptoms clinicians should consider endoscopy:

- Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained
- With suspected GORD who are thinking about surgery
- With H pylori that has not responded to second- line eradication
- Eradication can be confirmed with a urea breath test.

Upper Endoscopy should only be performed if the patient meets one of the following criteria:	**Delete as appropriate**	
Urgent: (Within two weeks) Any dysphagia (difficulty in swallowing), to prioritise urgent assessment of dysphagia please refer to the Edinburgh Dysphagia Score **OR**	Yes	No
Aged 55 and over with weight loss and any of the following: — Upper abdominal pain — Reflux — Dyspepsia (4 weeks of upper abdominal pain or discomfort — Heartburn — Nausea or vomiting	Yes	No
Those aged 55 or over who have one or more of the following: — Treatment resistant dyspepsia (as above), upper abdominal pain with low haemoglobin level (blood level) **OR** — Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain **OR** — Nausea and vomiting with any of the following: weight loss, reflux, dyspepsia, upper abdominal pain.	Yes	No
For the assessment of Upper GI bleeding: — For patients with haematemesis, calculate Glasgow Blatchford Score at presentation and any high-risk patients should be referred — Endoscopy should be performed for unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation	Yes	No

— Endoscopy should be performed within 24 hours of admission for all other patients with upper gastrointestinal bleeding.		
For the investigation of symptoms: — Clinicians should consider endoscopy: — Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained — With suspected GORD who are thinking about surgery — With H pylori that has not responded to second- line eradication • Eradication can be confirmed with a urea breath test.	Yes	No
For the management of specific cases		
For H pylori and associated peptic ulcer: Eradication can be confirmed with a urea breath test, however if peptic ulcer is present repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer	Yes	No
For Barrett's oesophagus: • The non-endoscopic test called Cytosponge can be used (where available) to identify those who have developed Barrett's oesophagus as a complication of long-term reflux and thus require long term surveillance for cancer risk • Consider endoscopy to diagnose Barrett's Oesophagus if the person has GORD (endoscopically determined oesphagitis or endoscopy – negative reflux disease) • Consider endoscopy surveillance if person is diagnosed with Barrett's Oesophagus.	Yes	No
For coeliac disease: Patients aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy.	Yes	No
Surveillance endoscopy: • Surveillance endoscopy should only be offered in patients fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Many of this patient group are elderly and/or have significant comorbidities. Senior clinician input is required before embarking on long term endoscopic surveillance • Patients diagnosed with extensive gastric atrophy (GA) or gastric intestinal metaplasia, (GIM) (defined as affecting the antrum and the body) should have endoscopy surveillance every three years • Patients diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer of persistent Hpylori infection, should undergo endoscopy every three years.	Yes	No
Screening endoscopy can be considered in: • European guidelines (2015) for patients with genetic risk factors / family history of gastric cancer recommend genetics referral first	Yes	No

before embarking on long term screening. Screening is not appropriate for all patients and should be performed in keeping with European expert guidelines • Patients where screening is appropriate, for individuals aged 50 and over, with multiple risk factors for gastric cancer (e.g. H. Pylori infection, family history of gastric cancer - particularly in first degree relative -, pernicious anaemia, male, smokers).		
Post excision of adenoma: • Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate.	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information. If patient meets the above criteria then prior approval is not required.*

Endoscopy should be offered only as recommended in guidance from NICE and the British Society for Gastroenterology which are incorporated in the guidance.
NICE guideline on coeliac disease: recognition, assessment and management | The British Society of Gastroenterology (bsg.org.uk)

*Glasgow-Blatchford Bleeding Score (GBS) - MDCalc

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgical intervention for chronic rhinosinusitis

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS

Evidence Based Interventions Phase II policy confirms that referral to secondary care will only be funded when the following criteria are met:

	Delete as appropriate	
In ordinary circumstances, referral should not be considered unless the following criteria are met*		
A clinical diagnosis of chronic rhinosinusitis has been made in primary care and patient still has moderate/ severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation	Yes	No
In the case of chronic rhinosinusitis with nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg)	Yes	No
Patient has nasal symptoms with an unclear diagnosis in primary care	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information*

Any patient with unilateral symptoms or clinical findings, orbital, or neurological features should be referred urgently / via 2-week wait depending on local pathways

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Knee MRI for suspected meniscal tears

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation will only be funded when the following criteria are met:

The majority of patients who initially present in primary care with knee symptoms, no red flags and no history of acute knee injury or a locked knee do not need an MRI investigation and can be treated with non-operative supportive measures.

In ordinary circumstances, referral for MRI for meniscal tears should only be considered if the patient has the one of the following:*	**Delete as appropriate**	
• clear history of a significant acute knee injury and mechanical symptoms	Yes	No
• locked knee	Yes	No
• persistent mechanical knee symptoms of more than three months duration	Yes	No

**If clinician considers need for intervention on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

Appropriate Colonoscopy in the management of hereditary colectoral cancer

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation/procedures will only be funded when the following criteria are met:

Colonoscopy should only be offered to at risk people identified through risk stratification Colonoscopy should not be used as first-line investigation in all patients. Colonoscopy is an invasive procedure which carries a small risk of serious complications, for example intestinal perforation. Colonoscopy should be offered only as recommended by British Society for Gastroenterology which is incorporated in this guidance. Risk stratification is instead recommended to identify at-risk patients, and non-invasive tests and other procedures such as a Faecal Immunochemical Test (FIT test) should be used as a first-line investigation where appropriate.

The relevant BSG colonoscopy surveillance guidelines should be followed.

British Society of Gastroenterology surveillance guidelines for colonoscopy in the management of hereditary colorectal cancer: https://www.bsg.org.uk/resource/guidelines-for-the-management-of-hereditary-colorectal-cancer.html.

	Yes	No
Family history of CRC		
For individuals with moderate familial CRC risk:		
• Offer one-off colonoscopy at age 55 years		
• Subsequent colonoscopic surveillance should be performed as determined by post-polypectomy surveillance guidelines.		
For individuals with high familial CRC risk (a cluster of 3x FDRs with CRC across >1 generation):		
• Offer colonoscopy every 5 years from age 40 years to age 75 years.		
Lynch Syndrome (LS) and Lynch-like Syndrome		
For individuals with LS that are *MLH1* and *MSH2* mutation carriers:		
• Offer colonoscopic surveillance every 2 years from age 25 years to age 75 years.		
• For individuals with LS that are *MSH6* and *PMS2* mutation carriers:		
• Offer colonoscopic surveillance every 2 years from age 35 years to age 75 years.		
For individuals with Lynch-like Syndrome with deficient MMR tumours without hypermethylation/BRAF pathogenic variant and no pathogenic constitutional pathogenic variant in MMR genes (and their unaffected FDRs), and no evidence of biallelic somatic MMR gene inactivation:		
• Offer colonoscopic surveillance every 2 years from age 25 years to age 75 years.		
Early Onset CRC (EOCRC)		
For individuals diagnosed with CRC under age 50 years, where hereditary CRC symptoms have been excluded:		
• Offer standard post-CRC colonoscopy surveillance after 3 years		
• Then continue colonoscopic surveillance every 5 years until eligible for national screening.		
Serrated Polyposis Syndrome (SPS)		
For individuals with SPS:		
• Offer colonoscopic surveillance every year from diagnosis once the colon has been cleared of all lesions >5mm in size		

• If no polyps ≥ 10mm in size are identified at subsequent surveillance examinations, the interval can be extended to every 2 years.		
For first degree relatives of patients with SPS:		
• Offer an index colonoscopic screening examination at age 40 or ten years prior to the diagnosis of the index case		
• Offer a surveillance colonoscopy every 5 years until age 75 years, unless polyp burden indicates an examination is required earlier according to post-polypectomy surveillance guidelines.		
Multiple Colorectal Adenoma (MCRA)		
For individuals with MCRA (defined as having 10 or more metachronous adenomas):		
• Offer annual colonoscopic surveillance from diagnosis to age 75 years after the colon has been cleared of all lesions >5mm in size — If no polyps 10mm or greater in size are identified at subsequent surveillance examinations, the interval can be extended to 2 yearly.		
Familial Adenomatous Polyposis (FAP)		
For individuals confirmed to have FAP on predictive genetic testing:		
• Offer colonoscopic surveillance from 12-14 years		
• Then offer surveillance colonoscopy every 1-3 years, personalised according to colonic phenotype.		
For individuals who have a first degree relative with a clinical diagnosis of FAP (i.e. “at risk”) and in whom a *APC* mutation has not been identified:		
• Offer colorectal surveillance from 12-14 years		
• Then offer every 5 years until either a clinical diagnosis is made and they are managed as FAP or the national screening age is reached.		
MUTYH-associated Polyposis (MAP)		
For individuals with MAP:		
• Offer colorectal surveillance from 18-20 years, and if surgery is not undertaken, repeat annually.		
For monoallelic MUTYH pathogenic variant carriers:		
• The risk of colorectal cancer is not sufficiently different to population risk to meet thresholds for screening and routine colonoscopy is not recommended.		
Peutz-Jeghers Syndrome (PJS)		
For asymptomatic individuals with PSJ:		
• Offer colorectal surveillance from 8 years		
• If baseline colonoscopy is normal, deferred until 18 years, however if polyps are found at baseline examination, repeat every 3 years.		
For symptomatic patients, investigate earlier.		
Juvenile Polyposis Syndrome (JPS)		
For asymptomatic individuals with JPS:		
• Offer colorectal surveillance from 15 years		
• Then offer a surveillance colonoscopy every 1-3 years, personalised according to colorectal phenotype.		
For symptomatic patients, investigate earlier.		
For some patients with multiple risk factors for CRC, for example those with Lynch Syndrome and inflammatory bowel disease/multiple polyps, more frequent colonoscopy may be indicated. This needs to be guided by clinicians but with a clear scientific rationale linked to risk management.		

**If clinician considers need for colonoscopy on clinical grounds outside of these criteria, please refer to the CCG’s Individual Funding Request policy for further information.*

Repeat Colonoscopy of the lower intestine

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation/procedures will only be funded when the following criteria are met:

Surveillance colonoscopy is not always recommended following surgical resection of colorectal lesions. Surveillance colonoscopy should be offered only as recommended by the British Society for Gastroenterology which is incorporated in this guidance. Instead, risk stratification is recommended to identify patients who require follow up colonoscopy.

The relevant BSG colonoscopy surveillance guidelines should be followed

Follow the British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection:
https://www.bsg.org.uk/resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectalcancer-resection-surveillance-guidelines.html

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Risk Surveillance Criteria for Colonoscopy	**Yes**	**No**
Either of the following put individuals at high-risk for future colorectal cancer following polypectomy: — 2 or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size **OR** containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia); **OR** — 5 or more premalignant polyps.	**Yes**	**No**
Surveillance colonoscopy after polypectomy **For individuals at high-risk and under the age of 75 and whose life expectancy is greater than 10 years:** — Offer one-off surveillance colonoscopy at 3 years.	Yes	No
For individuals with no high-risk findings: — No colonoscopic surveillance should be undertaken — Individuals should be strongly encouraged to participate in their national bowl screening programme when invited. **For individuals not at high-risk who are more than 10 years younger than the national bowel screening programme lower age-limit, consider for surveillance colonoscopy after 5 or 10 years, individual to age and other risk factors.**	Yes	No
Surveillance colonoscopy after potentially curative CRC resection:	Yes	No

— Offer a clearance colonoscopy within a year after initial surgical resection — Then offer a surveillance colonoscopy after a further 3 years — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.		
Surveillance after pathologically en bloc R0 EMR or ESD of LNPCPs or early polyp cancers: — No site-checks are required — Offer surveillance colonoscopy after 3 years — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.	Yes	No
Surveillance after piecemeal EMR or ESD of LNPCPs (large nonpedunculated colorectal polyps of at least 20mm in size): — Site-checks at 2-6 months and 18 months from the original resection. Once no recurrence is confirmed, patients should undergo post-polypectomy surveillance after 3 years — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.	Yes	No
Surveillance where histological completeness of excision cannot be determined in patients with: (i) a non-pedunculated polyps of 10-19mm in size, or (ii) an adenoma containing high-grade dysplasia, or (iii) a serrated polyp containing any dysplasia: — Site-check should be considered within 2-6 months — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria	Yes	No
Ongoing colonoscopic surveillance: — To be determined by the findings at each surveillance procedure, using the high-risk criteria to stratify risk — Where there are no high-risk findings, colonoscopic surveillance should cease but individuals should be encouraged to participate in the national bowel screening programme when invited.	**Yes**	**No**

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Arthroscopic surgery for meniscal tears

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase 2 policy confirms this investigation/procedure will only be funded when the following criteria are met:

The vast majority of patients with a meniscal tear should be initially treated non-operatively and should not have arthroscopic meniscectomy as a first line treatment. Non-operative treatment is highly effective with patient education using verbal and written materials, physiotherapy and weight loss interventions. Exercise should comprise both local muscle strengthening and general aerobic fitness. Paracetamol and topical NSAIDs should be first line pharmacological pain management strategies. Many patients treated this way will improve and do not require surgery.

	Delete as appropriate	
In ordinary circumstances, arthroscopic meniscal surgery should only be offered as a first line treatment when the following criteria apply:*		
The patient has a locked knee	Yes	No
The patient has a bucket handle tear of the meniscus is present	Yes	No
Patient has had an acute injury and an MRI scan reveals a potentially repairable meniscus tear	Yes	No
Patients considering arthroscopic knee surgery should go through a shared decision-making process	Yes	No

**If clinician considers need for surgical intervention on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Cystoscopy for men with uncomplicated lower urinary tract symptoms

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation/procedure will only be funded when the following criteria are met:

Assessment of men with LUTS should focus initially on a thorough history and examination, complemented by use of a frequency – volume chart, urine dipstick analysis and International Prostate Symptom Score where appropriate. This assessment may be initiated in primary care settings.

Specialist assessment should also incorporate a measurement of flow rate and post void residual volume.

In the context of male lower urinary tract symptoms (LUTS), cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example).

This guidance applies to male adults aged 19 years and over.

	Delete as appropriate	
In ordinary circumstances, cystoscopy should only be offered to men with LUTS in the presence of the following features from their history:*		
Recurrent infection	Yes	No
Sterile pyuria	Yes	No
Haematuria	Yes	No
Profound symptoms	Yes	No
Pain	Yes	No
Additional information may also inform clinical decision making around the use of cystoscopy in men with LUTS. Such factors might include but not limited to		
Smoking history	Yes	No
Travel or occupational history suggesting high risk of malignancy	Yes	No
Previous surgery	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Surgical removal of kidney stones

Please refer to NICE NG118 (recommendation 1.5) for full details on the assessment and management of renal and ureteric stones:
https://www. nice.org.uk/guidance/ng118/chapter/Recommendations.

Evidence Based Interventions Phase II policy confirms this investigation will only be funded when the following criteria are met:

Adult renal stones

Size		Yes	No
< 5mm	If asymptomatic, was watchful waiting considered?		
5-10mm	Was watchful waiting considered?		
	Was shockwave lithotripsy(SWL) first line treatment?		
10-20mm	Was SWL first line treatment		
	Was ureteroscopy (URS) second line treatment if SWL contraindicated/ineffective?		
> 20mm	(including staghorn) was percutaneous nephrolithotomy (PCNL) performed?		

Adult ureteric stones

Size		Yes	No
<5mm	If asymptomatic was watchful waiting (with medical therapy e.g. Alpha blocker for use with distal stones) considered?		
5-10mm	Was SWL first-line treatment?		
10-20mm	Was SWL considered?		
10-20mm	Was URS first line treatment? Y/N		

Surgical intervention for benign prostatic hyperplasia

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this procedure will only be funded when the following criteria are met:

	Delete as appropriate	
In ordinary circumstances,surgical intervention should not be considered unless the following criteria are met*		
Surgery should only be offered to men with severe voiding symptoms	Yes	No
Conservative management options and drug treatment have been unsuccessful	Yes	No
History of urinary tract infections, bladder stones or urinary retention, or bothersome and persistent LUTS alongside high or unchanged International Prostate Symptom Scores	Yes	No
If surgical intervention is considered patient has been counselled thoroughly regarding alternatives to and outcomes from surgery. *(Complications of the intervention vary and include discomfort, bleeding, and rarely urinary incontinence).*	Yes	No

**If clinician considers need for surgical intervention on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Surgical intervention for chronic rhinosinusitis

Please refer to National Guidance for full details, complete the checklist in secondary care and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this procedure will only be funded when the following criteria are met:

There are a number of medical conditions whereby endoscopic sinus surgery may be required outside of the criteria listed in the box below and in these cases they should not be subjected to the criteria and continue to be routinely funded: These conditions are as follows:

- Any suspected or confirmed neoplasia
- Emergency presentations with complications of sinusitis (e.g. orbital abscess, subdural or intracranial abscess)
- Patients with immunodeficiency
- Fungal Sinusitis
- Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (NSAID-ERD, Samter's Triad, Aspirin Sensitivity, Asthma, CRS)
- Treatment with topical and / or oral steroids contra-indicated.
- As part of surgical access or dissection to treat non-sinus disease (e.g. pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery if possible, by nasal endoscopy and/or a CT sinus scan.

	Delete as appropriate	
Patients can be considered for endoscopic sinus surgery when the following criteria are met:		
A diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and / or CT scan AND	Yes	No
Disease-specific symptom patient reported outcome measure confirms moderate to severe symptoms e.g. Sinonasal Outcome Test (SNOT-22) after trial of appropriate medical therapy (including counselling on technique and compliance) as outlined in RCS/ENT-UK commissioning guidance 'Recommended secondary care pathway'. AND	Yes	No
Pre-operative CT sinus scan has been performed and confirms presence of CRS. Note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient's pathway. AND	Yes	No
Patient and clinician have undertaken appropriate shared decision making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention. OR	Yes	No
In patients with recurrent acute sinusitis, nasal examination is likely to be relatively normal. Ideally, the diagnosis should be confirmed during an acute attack	Yes	No

**If clinician considers need for clinical intervention on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Removal of adenoids in glue ear

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this procedure will only be funded when the following criteria are met:

Adjuvant adenoidectomy should not be routinely performed in children undergoing grommet insertion for the treatment of otitis media with effusion.

The following checklist should be completed and referral to IFR panel made in all cases.

	Delete as appropriate	
Adjuvant adenoidectomy for the treatment of glue ear should only be offered when one or more of the following clinical criteria are met:		
• The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy	Yes	No
• The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion	Yes	No
• The child is undergoing grommet surgery for treatment of recurrent acute otitis media	Yes	No

This guidance only refers to children undergoing adenoidectomy for the treatment of glue ear and should not be applied to other conditions where adenoidectomy should continue to be routinely funded. These include:

- As part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (e.g. as part of adenotonsillectomy)
- As part of the treatment of chronic rhinosinusitis in children
- For persistent nasal obstruction in children and adults with adenoidal hypertrophy
- In preparation for speech surgery in conjunction with the cleft surgery team

**All requests for this treatment should be referred to the CCG's Individual Funding Request panel and should be accompanied by a clinical letter and a copy of the GP referral.*

Diagnostic coronary angiography for low risk, stable chest pain

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation will only be funded when the following criteria are met:

NICE guidelines recommend that where a diagnosis of chest pain cannot, by clinical assessment alone, exclude stable angina, 64-slice CT coronary angiography should be offered as first-line. Invasive coronary angiography should only be offered to patients with significant findings on CT coronary angiogram or with inconclusive further imaging.

When results of non-invasive functional imaging are inconclusive and patients are assessed as having low risk, stable cardiac pain, invasive coronary angiography (cardiac catheterisation) should be offered only as third-line investigation. Patients who have chest pain that is not an Acute Coronary Syndrome (ACS), but there is concern that it is due to an ischemic cause (stable angina) should, in the first instance, be offered a CT Coronary angiography (64 slice or above).

Invasive coronary angiography should be offered to patients who meet one of the following criteria:	**Delete as appropriate**	
There have been significant findings on the patients CT coronary angiogram ie ≥ 70% diameter stenosis of at least one major epicardial artery segment or ≥ 50% diameter stenosis in the left main coronary artery.	Yes	No
There has been inconclusive CT coronary angiography AND inconclusive functional imaging for myocardial ischemia in the following forms	Yes	No
— Stress echocardiography; or	Yes	No
— First-pass contrast-enhanced magnetic resonance (MR) stress perfusion; or	Yes	No
— MR imaging for stress-induced wall motion abnormalities; or	Yes	No
— Fractional flow reserve CT (FFR-CT); or	Yes	No
— Myocardial perfusion scintigraphy with single photon emission computed tomography (MPS with SPECT).	Yes	No

**If clinician considers need for procedure on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Lumbar discectomy

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this procedure will only be funded when the following criteria are met:

Discectomy may be offered to patients with compressive nerve root signs and symptoms lasting > 3 months despite best efforts with non-operative management. (previously 6 weeks)

In ordinary circumstances, the surgeon should not consider discectomy unless the patient meets the following criteria.*	**Delete as appropriate**	
Patient has experienced compressive nerve root signs and symptoms lasting three months or more (except in severe cases) despite best efforts with non-operative management.	Yes	No

**If clinician considers need for surgical intervention on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

***Please note: This guideline is not intended to cover patients who demonstrate a deterioration in neurological function (e.g. objective weakness, sexual dysfunction, cauda equina syndrome). These patients require an urgent referral to an acute spinal centre for further evaluation and imaging, as non-operative treatment may lead to irreversible harm*.**

Appendix 2 – Procedures with information on ICE
Procedures not requiring checklist, but information should be put on ICE

Table 2 below lists the procedures to which the national Evidence Based Interventions Phase 2 guidance applies. These interventions do not require a checklist but may require information to be placed on ICE.

Table 2

Procedure	Guidance for ICE
2F **Troponin test**	National Based Interventions policy: P.21 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Troponin testing should be used to diagnose acute myocardial infarction, in suspected myocarditis and the monitoring of chemotherapy related myocardial damage. Troponin testing should only be used in cases where a clinical diagnosis of acute coronary syndrome is suspected or for prognostic purposes when pulmonary embolism is confirmed. High-sensitivity troponin measurements should not be considered in isolation but interpreted alongside the clinical presentation, the time from onset of symptoms, the 12-lead resting ECG, pre-test probability of NSTEMI, the possibility of chronically elevated troponin levels in some people and that 99th percentile thresholds for troponin I and T may differ between sexes. If ACS is not suspected, high-sensitivity troponin test should not be used. For people at low risk of myocardial infarction only perform a second high sensitivity troponin test if the first troponin test at presentation is positive. Diagnosis of myocardial infarction is the detection of a rise and/or fall of cardiac troponin with at least one value above the 99th percentile of the upper reference limit and at least one of the following: — symptoms suggesting myocardial ischaemia — new / presumed new significant ST-segment-T wave (ST-T) changes or new left bundle branch block (LBBB) — development of pathological Q waves on the ECG — imaging evidence of new loss of viable myocardium or new regional wall motion abnormality — identification of an intracoronary thrombus by angiography. The appropriate use of high-sensitivity troponin testing should reduce the need for further investigation, result in shorter stays in hospital and overall result in cost-savings (if used in an early rule out clinical protocol).

	According to this recommendation, if acute coronary syndrome is suspected in a primary care setting, a referral should be made for prompt investigation and treatment.
2P **ERCP in acute gallstone pancreatitis without cholangitis**	National Based Interventions policy: P.44 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Early endoscopic retrograde cholangiopancreatography (ERCP) for acute gallstone pancreatitis without cholangitis is not recommended. Early ERCP in the treatment of acute gallstone pancreatitis, should only be performed if there is evidence of cholangitis or ongoing obstruction of the biliary tree. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours.
2R **Appendicectomy without confirmation of appendicitis**	National Based Interventions policy: P.48 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Consider imaging of patients with the suspicion of acute appendicitis in a defined clinical pathway. Where patients present with a high clinical suspicion of appendicitis, then imaging may not be necessary. If there is clinical doubt then imaging can reduce the negative appendicectomy rate. Most patients should have an ultrasound as the first-line investigation. If the diagnosis remains equivocal, a contrast-enhanced CT (CECT, preferably low dose) can be performed to give a definitive diagnosis prior to the patient returning to the surgical unit for a decision on management. A pathway like this is dependent on the availability of an adequately skilled Radiologist (Consultant or Registrar) or Sonographer to perform the ultrasound assessment in a timely fashion. If this is not possible discretion should be used to proceed directly to limited dose CECT of the abdomen and pelvis.
2S **Imaging for lower back pain**	National Based Interventions policy: P.50 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica in the absence of red flags, or suspected

	serious underlying pathology following medical history and examination. Imaging in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to: cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease. Further information can be accessed at the relevant NICE guideline for these conditions. Patients presenting with low back pain and sciatica should be reviewed in accordance with the low back pain and sciatica guidance (https://www. nice.org.uk/guidance/ng59). Patients presenting with low back pain without sciatica should be reviewed and if none of the above serious underlying pathology are suspected, primary care management typically includes reassurance, advice on continuation of activity with modification, weightloss, analgesia, manual therapy and reviewing patients who are high risk of 51 Academy of Medical Royal Colleges EBI - List 2 Guidance developing chronic pain (i.e. STaRT Back). NICE guidelines recommend using a risk assessment and stratification tool, (e.g. STaRT Back), and following a pathway such as the National Back and Radicular Pain Pathway, to inform shared decision making and create a management plan. Consider a combined physical and psychological programme for management of sub-acute and chronic low back pain (greater than 3 to 6 months duration) e.g. Back Skills Training (BeST). Consider referral to a specialist centre for further assessment and management if required. Imaging within specialist centres is indicated only if the result will change management.
2T **Knee MRI when symptoms are suggestive of osteoarthritis**	National Based Interventions policy: P.53 EBI_list2_guidance_050121.pdf (aomrc.org.uk) In primary care, where clinical assessment is suggestive of knee osteoarthritis, imaging is not usually necessary. Weight bearing radiographs are the first line of investigation In secondary care the first-line investigation of potential knee Osteoarthritis is weight bearing plain radiography.

	If the patient has a pattern of disease that allows surgical treatment to be adequately planned with plain radiographs, then MRI is not required. However, there are a number of situations where MRI of the osteoarthritic knee can be useful: — Patients who have severe symptoms but relatively mild OA on standard X-rays. In this situation the MRI offers more detail and can show much more advanced OA or Osteonecrosis within the knee — In working up a patient for possible HTO or partial knee replacement an MRI can be a very useful investigation focusing on the state of the anterior cruciate ligament and state of the retained compartments. In summary an MRI scan can be a useful investigation in the contemporary surgical management of osteoarthritis, giving critical information on the pattern of disease and state of the soft tissues. However, requesting an MRI scan when it is not indicated potentially prolongs further waiting times for patients, can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for appropriate patients.
2W **Imaging for shoulder pain**	National Based Interventions policy: P.60 EBI_list2_guidance_050121.pdf (aomrc.org.uk) For patients who initially present with shoulder pain in primary or intermediate care, the first line of radiological investigation should be a plain x-ray. X-rays diagnose most routine shoulder problems such as osteoarthritis, calcium deposits, rotator cuff arthropathy, impingement, fractures and primary and secondary tumours. If following an x-ray and clinical assessment, the diagnosis is still in doubt then a referral to the secondary care shoulder service is indicated where further specialist assessment and appropriate investigations including USS, CT scans and MRI scans can be arranged. The British Elbow and Shoulder Society (BESS) have produced treatment and referral guidelines for routine shoulder conditions (https://bess.ac.uk/patient-care-pathways-andguidelines/).

	If shoulder RED FLAGS are present, an urgent referral to secondary care should be arranged for further investigation and management: — Any history or suspicion of malignancy — Any mass or swelling — Suggestions of infection, e.g. red skin, fever or systemically unwell — Trauma, pain and weakness — Trauma, epileptic fit or electric shock leading to loss of rotation and abnormal shape. Injections for shoulder pain are often indicated as a first line of treatment. The common areas injected are the subacromial space, the glenohumeral joint and the acromioclavicular joint. The most common injection is a subacromial injection. Guided injections (usually utilising ultrasound) are more expensive than unguided injections. Evidence now indicates there is no additional benefit from a guided subacromial injection over an unguided landmark injection and so these are no longer recommended in primary, intermediate and Secondary care during routine management of patients with subacromial shoulder pain. The use of other guided injections for glenohumeral joint and acromioclavicular joint problems should only be offered under the guidance of a secondary care shoulder service responsible for definitive treatment of these patients.
X **MRI scan for hip for osteoarthritis**	National Based Interventions policy: P.63 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Do not request a hip MRI when the clinical presentation (history and examination) and X-rays demonstrate typical features of OA. MRI scans rarely add useful information to guide diagnosis or treatment. Requesting MRI scans further prolongs waiting times for patients. Importantly it can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for patients with diagnoses other than OA of the hip. The diagnosis of hip OA can be effectively made based upon the patient's history and physical examination. NICE recommends diagnosing osteoarthritis clinically without investigations in patients who: — Are 45 or over AND — Have activity-related joint pain AND — Have either no morning joint-related stiffness or morning stiffness that

	lasts no longer than 30 minutes. It is important to exclude other diagnoses, especially when red flags are present. If imaging is necessary, the first-line investigation should be plain x-ray. An MRI or urgent onward referral may be warranted in some circumstances. These include: — Suggestions of infection, e.g. pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis — Trauma — History or family history of an inflammatory arthropathy — Mechanical, impingement type symptoms — Prolonged and morning stiffness — History of cancer or corresponding risk factors — Suspected Osteonecrosis / Avascular necrosis of the hip — Suspected transient osteoporosis — Suspected periarticular soft tissue pathology e.g. abductor tendinopathy Important differential diagnoses include inflammatory arthritis (for example, rheumatoid arthritis), femoro-acetabular impingement, septic arthritis and malignancy (bone pain).
2AA **Pre-op chest x ray**	National Based Interventions policy: P.69 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Pre-operative chest radiographs should only be routinely performed when one or more of the following criteria apply: • Patients undergoing cardiac or thoracic surgery • Patients undergoing organ transplantation or live organ donation • The request of the anaesthetist in the following: - Those with suspected or established cardio-respiratory disease, who have not had a chest radiograph in the previous 12 months, and who are likely to go to critical care after surgery. - Those with a recent history of chest trauma - Patients with a significant smoking history who have not had a chest radiograph in the previous 12 months Those with malignancy and possible lung metastases

	- Those undergoing a major abdominal operation, who are at high risk of respiratory complications.
2BB **Pre op ECG**	National Based Interventions policy: P.70 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Pre-operative electrocardiograms should not be routinely performed in low-risk, non-cardiac, adult elective surgical patients. Pre-operative electrocardiograms may be appropriately performed when the following criteria apply: - Patients with an American Society of Anaesthesiologists (ASA) physical classification* status of 3 or greater and no ECG results available for review in the last 12 months. - Patients with a history of cardiovascular or renal disease, or diabetes. - Patients with any history of potential cardiac symptoms (e.g. cardiac chest pain, palpitations, unexplained syncope or breathlessness) or a new murmur, that has not previously been investigated. - Patients over the age of 65 attending for major surgery. *ASA Physical Status Classification System | American Society of Anesthesiologists (ASA) (asahq.org)
2CC **Prostate-specific antigen (PSA) test**	National Based Interventions policy: P.72 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Where PSA testing is clinically indicated (see below), or requested by the man aged 50 and over, he should have a careful discussion about the potential risks and benefits of PSA testing which allows for shared decision making before a PSA test. Various tools are available to assist with shared decision making. PSA testing should be considered in asymptomatic men over age 40 who are at higher risk of prostate cancer due if they are Black and/or have a family history of prostate cancer. PSA testing should be considered when clinically indicated (ideally after counselling on the potential risks and benefits of testing) in men when there is clinical suspicion of prostate cancer, which may include the following symptoms: — Lower urinary tract symptoms (LUTS), such nocturia, urinary frequency, hesitancy, reduced flow, urgency or retention. — Erectile dysfunction. — Visible haematuria. — Unexplained symptoms that could be due to advanced prostate cancer

	(for example lower back pain, bone pain, weight loss). PSA testing for prostate cancer is not recommended in asymptomatic men (unless they are at high risk of prostate cancer i.e. Black and/or family history) is not recommended. This is because the benefits have not been shown to clearly outweigh the harms. In particular, there is concern about the high risk of false positive results. Where PSA test results are mildly raised above the age specific range for an individual patient, it may be appropriate to repeat the test within two to three months to monitor the trend. *Note: PSA testing for prostate cancer should be avoided if the man has:* *— An active or recent urinary infection (PSA may remain raised for many* *months).* *— Had a prostate biopsy in the previous 6 weeks* *both of which are likely to raise PSA and give a false positive result.*
2DD **Liver function, Creatinine kinase** **Lipid level tests – (Lipid lowering therapy)**	National Based Interventions policy: P.75 EBI_list2_guidance_050121.pdf (aomrc.org.uk) **Creatine Kinase Testing** — Creatine kinase should not be routinely monitored in asymptomatic people who are taking lipid modification therapy — Creatine kinase measurement is indicated: — Prior to lipid modification therapy initiation in patients who have experienced generalised, unexplained muscle pains or weakness (whether or not associated with previous lipid-monitoring therapy) — If a patient develops muscle pains or weakness whilst on lipid modification therapy. **Liver Function Testing** — Baseline liver function should be measured before starting lipid modification therapy — Liver function should be measured within 3 months of starting treatment and at 12 months, but not again unless clinically indicated — Routine monitoring of liver function tests in asymptomatic people is not indicated after 12 months of initiating lipid lowering therapy — ALT can be used as a measure of liver function. **Lipid Testing** — Measure full lipid profile by taking at least one lipid sample before starting lipid modification therapy. This should include measurement of

	total cholesterol, HDL cholesterol, non-HDL cholesterol and triglyceride concentrations. A fasting sample is not needed. — Total cholesterol, HDL cholesterol and non-HDL cholesterol should be measured in all people who have been started on high-intensity statin treatment (both primary and secondary prevention, including atorvastatin 20 mg for primary prevention) at 3 months of treatment and aim for a greater than 40% reduction in non-HDL cholesterol. — Consider an annual non-fasting blood test for non-HDL cholesterol to inform discussion at annual medication reviews.
2EE **Blood Transfusion**	National Based Interventions policy: P.78 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Do not give RBC transfusions to patients with B12, folate or iron deficiency anaemia unless there is haemodynamic instability. If haemodynamic instability is present, treat this with transfusion of appropriate blood components (do not delay emergency transfusions). Where, however, severe acute anaemia (Hb <70g/litre) exists that is symptomatic and prevents rehabilitation or mobilisation, those patients may benefit from a single unit of blood. For adult patients (or equivalent based on body weight for children or adults with low body weight) needing RBC transfusion, suggest restrictive thresholds and giving a single unit at a time except in case of exceptions below. Restrictive RBC transfusion thresholds are for patients who need RBC transfusions and who do not: — Have major haemorrhage or — Have acute coronary syndrome or — Need regular blood transfusions for chronic anaemia. 79 Academy of Medical Royal Colleges EBI - List 2 Guidance While transfusions are given to replace deficient red blood cells, they will not correct the underlying cause of the anaemia. RBC transfusions will only provide temporary improvement. It is important to investigate why patients are anaemic and treat the cause as well as the symptoms. Note: Consider whether a dramatic fall in haemoglobin could be due to a severe haemolytic episode and not associated with any of the 3 exceptions. This would also be a possible indication to transfuse more than one unit at a time. When using a restrictive RBC transfusion threshold,

	consider a threshold of 70 g/litre and a haemoglobin concentration target of 70–90 g/litre after transfusion. For patients with acute coronary syndrome, a RBC transfusion threshold of 80 g/litre should be considered and a haemoglobin concentration target of 80–100 g/litre after transfusion. For patients requiring regular transfusion for chronic anaemia, NICE advise defining thresholds and haemoglobin concentration targets for each individual.

Appendix 3 – Commissioning Guidelines for Specialist Plastic Surgery Procedures

BACKGROUND AND INTRODUCTION

This policy sets out the criteria for access to NHS funded cosmetic specialist plastic surgery procedures.

Cosmetic surgery is any surgery carried out to enhance outward appearance. It is carried out on people with abnormal appearance from a range of clinical or congenital conditions or syndromes or as a result of surgery or injury. It can also be carried out to enhance appearance or to correct changes due to ageing or obesity.

In any health care system there are limits set on what is available and on what people can expect.

Clinical Commissioning Groups are required to achieve financial balance. They have a complex task in balancing this with individuals' rights to health care. It is the purpose of the criteria set out in this document to make the limits on cosmetic specialist plastic surgery procedures fair, clear and explicit.

Referrals within the NHS for the revision of treatments originally performed outside the NHS will not normally be permitted.

Referrals should where possible be made to the practitioner who carried out the original procedure.

This policy will be reviewed by the review date or in the light of any new guidance or clinical evidence, whichever is the earliest.

These guidelines cover a group of surgical procedures with cosmetic indications.

It is important to note that a substantial proportion of specialist plastic surgery is carried out by a number of specialities other than Plastic Surgery e.g. ENT Surgery, Ophthalmology, Maxillofacial Surgery, General Surgery and Dermatology. This policy only concerns procedures carried out in hospitals.

Severity of the condition, effectiveness of intervention requested, cost and cost effectiveness should all be taken into consideration in the decision making process.

Commissioning approval is required for NHS funding through the Individual Funding Request process prior to referral to the specialist clinician.

If funding is approval, the decision whether or not to go through with a particular procedure rests with the clinician and the patient in relation to the appropriateness of the procedure, its likelihood of success and risks of failure.

GENERAL GUIDELINES

1. Patients requiring reconstruction surgery to restore normal or near normal appearance or function following cancer treatment or post trauma do not fall within this policy.

2. For cosmetic procedures an NHS referral is inappropriate if the patient falls within the normal morphological range.

3. Patients should not be referred unless they are fit for surgery.

4. Patients should not be referred to the specialist service until approval has been obtained from the CCG through the IFR process and a copy of the approval should be appended to the referral.

5. Inevitably some patients may not fit the guidelines. If the referring clinician feels that a case merits funding on an exceptional basis they should discuss the case with the IFR team or submit an IFR with evidence of exceptionality to be considered by the panel.

6. Patients who have been operated on privately will not normally be eligible for NHS treatment for complications or secondary procedures. However there may be unusual or severe complications or circumstances that require transfer of a patient to the NHS for appropriate management.

7. Body Mass Index(BMI) is referred to as per SIGN[1] guidance :

Less than 18.5	Underweight
18.5 -24.9	Normal BMI
25.0 - 29.9	Overweight
30.0 - 39.9	Obese
40 or above	extremely obese

The BMI should be measured and recorded by the NHS.

8. Plastic surgery procedures will only normally be considered in patients with a BMI in the range of 18.5 to 27 unless weight is not relevant to the proposed surgery. Completion of Get First 6 month health improvement does not overrule this criteria for Barnsley patients.

9. Plastic surgery procedures will not be funded to alleviate psychological problems alone.

10. All decisions will be taken in the context of the overall financial position of the CCG.

11. Photographic evidence may be requested to facilitate thorough consideration of a case.

[1] SIGN (1996) Integrated Prevention and Management of Overweight and Obesity, Edinburgh

PROCEDURE SPECIFIC GUIDANCE

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**1. Abdominoplasty/ apronectomy (tummy tuck)**	**Abdominoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Abdominoplasty may rarely be considered on an exceptional basis, for example where the patient: • has lost a significant amount of weight (moved down two levels of the BMI SIGN guidance) and has a stable BMI, which would normally be below 27 for a minimum of 2 years, and • is experiencing severe difficulties with daily living, for example ambulatory or urological restrictions. Other factors may be considered: • recurrent severe infection or ulceration beneath the skin fold despite appropriate conservative treatment • significant abdominal wall deformity due to surgical scarring or trauma • problems associated with poorly fitting stoma bags
Plastic and Cosmetic surgery	**2. Breast Surgery**	
	2.1 Breast Augmentation	**Breast augmentation will not be routinely commissioned by the NHS for cosmetic reasons, for example for enhancement of small breasts, for tuberous breasts or for breast tissue involution (including post-partum changes).** Breast augmentation may rarely be considered on an exceptional basis, for example where the patient: • has a complete absence of breast tissue either unilaterally or bilaterally or • has suffered trauma to the breast during or after development and • has a BMI within the range 18.5 - 27 and • has completed puberty as surgery is not routinely commissioned for individuals who are below 19 years of age Patients who have received feminising hormones for an adequate length of time as part of a recognised treatment programme for gender dysphoria will only be considered when they meet the above criteria. Revision surgery will only be commissioned for implant rupture, or for other physical symptoms, for example capsule contracture associated with pain, and not for aesthetic indications. Implant replacement will only be considered if the original procedure was performed by the NHS.

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**2.2 Breast Reduction**	**Breast reduction will not routinely be commissioned by the NHS for cosmetic reasons.** Breast reduction may rarely be considered on an exceptional basis, for example where the patient: • has a breast measurement of cup size G or larger and • has a BMI in the range 18.5 - 27 or and • is 19 years of age or over and • has significant musculo-skeletal pain causing functional impairment which in the opinion of the referrer is likely to be corrected or significantly improved by surgery and • has tried and failed with all other advice and support, including a professional bra fitting and assessment by a physiotherapist where relevant **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf • NHS Website https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/ • The British Association of Plastic, Aesthetic and Reconstructive Surgeons http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
Plastic and Cosmetic surgery	**2.3 Breast Asymmetry**	**Surgery to correct breast asymmetry will not routinely be commissioned by the NHS for cosmetic reasons.** Surgery may rarely be considered on an exceptional basis, for example where the patient: • has a difference of at least 2 cup sizes and • has a BMI in the range 18.5-27 and • has tried and failed with all other advice and treatment, including a professional bra fitting and • has completed puberty - surgery is not normally commissioned below the age of 19 years **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**2.4 Breast Reduction for gynaecomastia (male)**	**Surgery to correct gynaecomastia will not routinely be commissioned by the NHS for cosmetic reasons.** Surgery may be considered on an exceptional basis, for example where the patient: • has more than 100g of sub areolar gland and ductal tissue (not fat) and • has a BMI in the range 18.5 - 27 or and • has been screened prior to referral to exclude endocrine and drug related causes (if drugs have been a factor then a period of one year since last use should have elapsed) and • has completed puberty - surgery is not routinely commissioned below the age of 19 years and • has been monitored for at least 1 year to allow for natural resolution if aged 25 or younger **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf • The British Association of Plastic, Aesthetic and Reconstructive Surgeons http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
Plastic and Cosmetic surgery	**2.5 Breast lift mastopexy**	**Mastopexy will not be routinely commissioned by the NHS for cosmetic reasons.** For example post lactation or age related ptosis but may be included as part of the treatment to correct breast asymmetry.
Plastic and Cosmetic surgery	**2.6 Correction of Nipple inversion**	**Surgical correction of benign nipple inversion will not be routinely commissioned by the NHS for cosmetic reasons.**
Plastic and Cosmetic surgery	**3. Hair**	
	3.1 Hair removal	**Hair removal will not be routinely commissioned by the NHS for cosmetic reasons.** Hair removal may be considered on an exceptional basis, for example where the patient: • has had reconstructive surgery resulting in abnormally located hair bearing skin or • has a pilonidal sinus resistant to conventional treatment in order to reduce recurrence risk
Plastic and Cosmetic Surgery	**3.2 Correction of Male Pattern Baldness**	**Treatments to correct male pattern baldness will not be routinely commissioned by the NHS for cosmetic reasons.**

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**3.3 Hair transplantation**	**Hair transplantation will not be routinely commissioned by the NHS for cosmetic reasons, regardless of gender.** Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is needed following cancer or trauma.
Plastic and Cosmetic surgery	**4. Acne scarring**	**Procedures to treat facial acne scarring will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example when the patient has very severe facial scarring unresponsive to conventional medical treatments.
Plastic and Cosmetic surgery	**5. Buttock, thigh and Arm lift surgery**	**Not Routinely Commissioned** **Surgery to remove excess skin from the buttock, thighs and arms will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • has an underlying skin condition, for example cutis laxa or • has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living and • has a normal BMI in the range18.5 - 27 for a minimum of 2 years
Plastic and Cosmetic surgery	**6. Congenital vascular abnormalities**	**Procedures for congenital vascular abnormalities will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis for lesions of considerable size on exposed areas only
Plastic and Cosmetic surgery	**7. Correction of Prominent Ears (Pinnaplasty)**	**Surgical correction of prominent ears will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • is aged 5-19 at the time of referral and the child (not the parents alone) expresses concern and • has very significant ear deformity or asymmetry **National Evidence Base** • NHS England Interim Commissioning Policy for Pinnaplasty/Otoplasty November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC027.pdf

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**8. Facelift**	**Facelift procedures, Botulinum toxin and dermal fillers will not be routinely commissioned by the NHS for cosmetic reasons** Cases may be considered on an exceptional basis, for example in the presence of an anatomical abnormality or a pathological feature which significantly affects appearance.
Plastic and Cosmetic surgery	**9. Lapiaplasty, Vaginoplasty and Hymen Reconsturction**	**Not Routinely Commissioned - Refer through IFR for exceptionality**
Plastic and Cosmetic surgery	**10. Liposuction**	**Liposuction will not be routinely commissioned by the NHS simply to correct the distribution of fat or for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient has significant lipodystrophy**.**
Plastic and Cosmetic surgery	**11. Rhinoplasty**	**Rhinoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example in the presence of severe functional problems. Post traumatic airway obstruction or septal deviation does not need funding approval**.**
Plastic and Cosmetic surgery	**12. Rhinophyma**	**Surgical/laser treatment of rhinophyma will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an individual basis, for example where the patient has functional problems and where conventional medical treatments have been ineffective.
Plastic and Cosmetic surgery	**13. Surgical Scars**	**Revision surgery for scars will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • has significant deformity, severe functional problems, or needs surgery to restore normal function or • has a scar resulting in significant facial disfigurement.
Plastic and Cosmetic surgery	**14. Thread veins/telangectasia**	**Not Routinely Commissioned - Refer through IFR for exceptionality**

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**15. Tattoo removal**	**Tattoo removal will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example where the patient: • has suffered a significant allergic reaction to the dye and medical treatments have failed • has been given a tattoo against their will (rape tattoo) **National Evidence Base** • NHS England Interim Commissioning Policy for Tattoo Removal November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC032.pdf
Plastic and Cosmetic surgery	**16. Surgical Repair of Torn Earlobes**	**Surgical repair of torn ear lobes or holes resulting from gauge piercing will not be commissioned by the NHS for cosmetic reasons.**

Appendix 4 - Patient Information Sheet

Evidence Based Interventions

Patient Information Leaflet to accompany the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy (Updated June 2020)

Background

During 2018, doctors, nurses and managers across the NHS, both locally in South Yorkshire and across the country, have been working hard to make sure that the interventions (treatments and operations) offered to all patients are the best ones available and that money is not spent on treatments that might not be effective.

The result is the Commissioning for Outcomes Policy (CFO), which came into effect from April 1st 2019. The policy has been agreed by all of the South Yorkshire and Bassetlaw Clinical Commissioning Groups (CCGs), which means that access to healthcare will be fair and equal for all patients in our region.

The policy is based upon the latest national guidance provided by the National Institute for Health and Care Excellence (NICE) and this has shown that some treatments or operations that have until now been routinely recommended might in fact not be the best option for some patients.

The aim of the policy is to make sure that the doctors and nurses involved in your care can offer you the most up to date treatments, based on the latest research and to ensure that NHS funds are spent on the things that will bring the greatest health benefits.

Your GP, hospital consultant or nurse specialist will discuss the different treatment options with you. Some operations or treatments will only be recommended for some patients and your doctor will assess whether or not you meet the clinical conditions or criteria.

If you meet the criteria then this will be the best treatment option for you and the procedure will be arranged.

If you don't meet the criteria then you will be offered the most effective treatment for your particular condition.

If you don't qualify for the treatment, but your doctor or nurse thinks that there are exceptional clinical circumstances in your case then they may submit an Individual Funding Request (IFR) to an independent panel for consideration.

Details about the IFR process and the guidance that is followed can be found by contacting your local CCG, please see the links below.

The table below shows all the interventions/procedures that are included within this Commissioning for Outcomes Policy

Speciality	Intervention
ANAESTHETICS	Pre-operative Chest X-ray (before an operation)
	Pre-operative ECG - Heart tracing (ECG) before an operation
CARDIOLOGY	Diagnostic coronary (invasive) angiography for low risk, stable chest pain
	Specialised blood tests (troponin) for investigation of chest pain
	Lipid Lowering Therapy - Regular blood tests when taking cholesterol lowering tablets
	Exercise ECG for screening for coronary heart disease
ENT	Grommets in children
	Grommets in Adults
	Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))
	Tonsillectomy
	Surgery for chronic sinusitis
	Removal of the adenoids (for glue ear and not OSA) Adenoidectomy
GENERAL SURGERY	Haemorrhoid surgery
	Varicose veins
	Removal of Benign Perianal skin lesions
	Cholecystectomy - Removal of an inflamed gallbladder
	Surgery for minimally symptomatic inguinal hernia
	Ingrown toenail
	Upper GI Endoscopy to investigate gut problems
	Appropriate Colonoscopy of the lower intestine
	Repeat / Follow up colonoscopy of the lower intestine
	Test of the gallbladder - ERCP in acute gallstone pancreatitis without cholangitis
	Appendicectomy without confirmation of appendicitis - Tests to confirm appendicitis
GYNAECOLOGY	Hysterectomy for management of heavy menstrual bleeding
	Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women
HAEMATOLOGY	Blood transfusions
OPTHALMOLOGY	Cataract Surgery
	Meibomian cyst (Chalazion)
	Upper Eyelid Blepharaplasty
ORTHOPAEDICS	Arthroscopic Subacrominal Decompression of the shoulder (ASAD)
	Knee arthroscopy for patients with osteoarthritis
	Injection for non-specific low back pain
	Surgery to fuse the bones in the back for back pain - Fusion surgery for mechanical axial low back pain
	Carpal tunnel Syndrome Surgery
	Common Hand Conditions - Dupuytrens release
	Common Hand conditions - Ganglion
	Common Hand Conditions - Trigger finger

	Hallux valgus surgery
	Total Knee replacement
	Total Hip Replacement
	Knee arthroscopic surgery for meniscal tears
	Lumbar Discectomy - Spinal surgery for a slipped disc
	Knee MRI when symptoms are suggestive of osteoarthritis
	Knee MRI for suspected meniscal tears
	Vertebral augmentation (vertebroplasty or Kyphoplasty) for painful osteoporotic vertebral fractures
	Imaging for shoulder pain
	MRI scan of the hip for arthritis
	Low back pain imaging
	Lumbar Radiofrequency facet joint denervation
PAEDIATRICS	Helmet therapy in the treatment of positional plagiocephaly in children*
PAIN CLINIC	Acupuncture for non-specific back pain
PLASTIC SURGERY	Breast reduction / asymmetry and Gynaecomastia
UROLOGY	Male circumcision
	Vasectomy under GA
	Surgical removal of kidney stones
	Cystoscopy for men with un-complicated lower urinary tract symptoms
	Surgical intervention for benign prostatic hyperplasia
	Prostate- specific antigen (PSA) testing

The CFO policy and the list of clinical criteria for each treatment are available on the internet at: https://www.healthandcaretogethersyb.co.uk/about-us/useful-documents

Further information about the policy, including how to raise concerns or make a complaint can be found at the links below, please choose the CCG that is responsible for the area where you live.

Please be assured that your details will remain confidential and will only be shared with relevant staff in order to address your concerns.

BARNSLEY
http://www.barnsleyccg.nhs.uk/about-us/feedback-and-enquiries.htm

Write to: Quality Team, NHS Barnsley CCG, Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY
Telephone: 01226 433772
Email: qualityteam.safehaven@nhs.net

For further advice you can also contact Healthwatch at; Priory Campus, Pontefract Road, Barnsley, South Yorkshire. S71 5PN or Tel: 01226 320106

BASSETLAW
Write to: Complaints Department, Retford Hospital, North Road, Retford, Notts, DN22 7XF
Telephone: 01777 863321
Email: BASCCG.CommunicationOffice@nhs.net

For further advice you can also contact Healthwatch at; Unit 2, Byron Business Centre, Duke St, Hucknall, Notts, NG15 7HP or Tel: 01159635179

DONCASTER
Write to: Patient Experience Manager, Doncaster CCG, Sovereign House, Heaven's Walk, Doncaster, DN4 5HZ
Telephone: 01302 566228
Email: Donccg.enquiries@nhs.net

For further advice you can also contact Healthwatch at: 3 Cavendish Court, South Parade, Doncaster, DN1 2JD or Tel: 0808 8010391

ROTHERHAM
http://www.rotherhamccg.nhs.uk/concerns-and-complaints.htm
Write to: Rotherham CCG, Oak House, Moorhead Way, Rotherham, South Yorkshire S66 1YY
Telephone: 01709 302108
Email: complaints@rotherhamccg.nhs.uk

For further advice you can also contact Healthwatch at: Thornbank House, 38 Moorgate Rd, Rotherham S60 2AG or Tel: 01709717130

SHEFFIELD
http://www.sheffieldccg.nhs.uk/about-us/contact-us.htm
Write to: Complaints Team, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU
Telephone: (0114) 305 1000
Email: SHECCG.complaints@nhs.net

For further advice you can also contact Healthwatch at: The Circle, 33 Rockingham Lane, Sheffield, S1 4FW or Tel: 01142536688

Appendix 5 – Diagnostic and Procedure Codes (v5)

For each of the interventions, the clinical definitions have been converted into combinations of one or more OPCS procedure codes and ICD-10 diagnosis codes. The following descriptors use Microsoft SQL Server structure but are easily adaptable to other systems.

For reference:

- A "%" symbol represents a wildcard for zero or more characters.
- Values in square brackets mean "one of these characters". E.g. [03] mean 0 or 3 and [0-3] means 0 or 1 or 2 or 3.
- The field "der_diagnosis_all" is a concatenation of all diagnosis fields in all episodes within the spell.

Please note this appendix is subject to national amendments. A copy of the latest code is available electronically on request from roccg.intelligence@nhs.net

National Evidence Based Interventions Phase 1 (1) and Phase 2 (2) and Local Evidence Based Interventions (Z)

Intervention		Diagnostic and procedure codes
1A	Intervention for snoring (not OSA)	when left(der.Spell_Dominant_Procedure,4) in ('F324','F325','F326') and der.Spell_Primary_Diagnosis not like '%G473%' and APCS.Age_At_Start_of_Spell_SUS between 18 and 120 then 'A_snoring'
1B	Dilatation & curettage for heavy menstrual bleeding	when left(der.Spell_Dominant_Procedure,4) in ('Q103') and apcs.der_diagnosis_all not like '%O0[0-8]%' and apcs.der_diagnosis_all not like '%O6[0-9]%' and apcs.der_diagnosis_all not like '%O7[0-5]%' then 'B_menstr_D&C'
1C	Knee arthroscopy with osteoarthritis	when der.Spell_Dominant_Procedure in ('W821','W822','W823','W828','W829','W851','W852','W853','W858','W859','W861+KNEE','W831+KNEE','W832+KNEE','W833+KNEE','W834+KNEE','W835+KNEE','W836+KNEE','W837+KNEE','W838+KNEE','W839+KNEE','W841+KNEE','W842+KNEE','W843+KNEE','W844+KNEE') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and der.Spell_Primary_Diagnosis like 'M1[57]%' then 'C_knee_arth'
1D	Injection for nonspecific low back pain without sciatica	when left(der.Spell_Dominant_Procedure,4) in ('A521','A522','A528','A529','A577','A735','V363','V368','V369','V382','V383','V384','V385','V386','V388','V389','V544','W903') and left(der.spell_primary_diagnosis,4) in ('G834','G551','M518','M519','M545','M549') and apcs.der_procedure_all like '%Z67[67]%' then 'D_low_back_pain_inj'

1E	Breast reduction	when left(der.Spell_Dominant_Procedure,4) in ('B311') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' then 'E_breast_red'
1F	Removal of benign skin lesions (EBI)	when left(der.Spell_Dominant_Procedure,4) in ('S063','S064','S065','S066','S067','S068','S069','S081','S082','S083','S088','S089','S091','S092','S093','S094','S095','S098','S099','S101','S102','S111','S112','D021','D022','D028','D029') and APCS.Der_Diagnosis_All not like '%C4[3469]%' then 'F_skin_lesions'
1F	Removal of benign skin lesions (Additions)	when (left(der.Spell_Dominant_Procedure,4) not in ('S063','S064','S065','S066','S067','S068','S069','S081','S082', 'S083','S088','S089' ,'S091','S092','S093','S094','S095','S098','S099','S101','S102','S111','S112', 'D021','D022','D028','D029','S103','S104','S105','S108','S109','S113','S114','S115','S118','S119') and der.Spell_Dominant_Procedure is not null and (der.spell_primary_diagnosis in ('D170', 'D171', 'D172', 'D173') or der.spell_primary_diagnosis like 'L82%') then 'F_skin_lesions (Addition)' when left (der.Spell_Dominant_Procedure,4) in ('S103','S104','S105','S108','S109','S113','S114','S115','S118','S119') and apcs.der_diagnosis_all not like '%C4[3469]%' then 'F_skin_lesions (Addition)'
1G	Grommets	when left(der.Spell_Dominant_Procedure,4) in ('D151','D289') and (der.Spell_Primary_Diagnosis like 'H65[23]%' or der.Spell_Primary_Diagnosis like 'H66[1-9]%') and (apcs.age_at_start_of_Spell_SUS between 1 and 17 or apcs.age_at_start_of_Spell_SUS between 7001 and 7007) then 'G_gromm'
1H	Tonsillectomy (EBI)	when left(der.Spell_Dominant_Procedure,4) in ('F341','F342','F343','F344','F345','F346','F347','F348','F349','F361') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and apcs.der_diagnosis_all not like '%G47%' and apcs.der_diagnosis_all not like '%J36%' then 'H_tonsil'
1H	Tonsillectomy (Additions)	when left (der.Spell_Dominant_Procedure,4) in ('F341','F342','F343','F344','F345','F346','F347','F348','F349','F361') and (der.spell_primary_diagnosis like 'G47%' or der.spell_primary_diagnosis like 'J36%') and der_diagnosis_all not like 'C[0-9][0-9]%' then 'H tonsil (IFR Required)'
1I	Haemorrhoid surgery	when left(der.Spell_Dominant_Procedure,4) in ('H511','H512','H513','H518','H519') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' then 'I_haemmor'
1J	Hysterectomy for heavy bleeding	when left(der.Spell_Dominant_Procedure,4) in ('Q072','Q074','Q078','Q079','Q082','Q088','Q089') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and apcs.der_diagnosis_all not like '%O0[0-8]%' and apcs.der_diagnosis_all not like '%O6[0-9]%' and apcs.der_diagnosis_all not like '%O7[0-5]%' then 'J_hysterec'
1K	Chalazia removal (EBI)	when left(der.Spell_Dominant_Procedure,4) in ('C121','C122','C124','C191','C198') and left(der.Spell_Primary_Diagnosis,4) in ('H001') and apcs.der_diagnosis_all not like '%C4[3469]%' then 'K_chalazia'

1K	Chalazia removal (additions)	when left(der.Spell_Dominant_Procedure,4) in ('C123','C125','C126','C128','C129','C131', 'C132','C133','C134','C138','C139','C161','C162','C163','C164','C165','C168','C169') and der.Spell_Primary_Diagnosis like 'H001%' and apcs.der_diagnosis_all not like '%C4[3469]%' then 'K_ Chalazion(additions)'
1L	Shoulder decompression (EBI)	when (der.Spell_Dominant_Procedure ='W844+SHOULDER' or (der.Spell_Dominant_Procedure ='O291' and apcs.der_procedure_all like '%Y767%')) and (der.Spell_Primary_Diagnosis like 'M754%' or der.Spell_Primary_Diagnosis like 'M2551%') then 'L_should_decom'
1L	Shoulder decompression (Additions)	when (der.Spell_Dominant_Procedure is not null and substr(der.Spell_Dominant_Procedure, 1,1) <> 'T' and (der.spell_primary_diagnosis like 'M750%' or der.spell_primary_diagnosis like 'M751%' or der.spell_primary_diagnosis like 'M754%') then 'L_should_decom (Addition)'
1M	Carpal tunnel syndrome release	when left(der.Spell_Dominant_Procedure,4) in ('A651','A659') and der.Spell_Primary_Diagnosis like '%G560%' then 'M_carpal'
1N	Dupuytren's contracture release	when left(der.Spell_Dominant_Procedure,4) in ('T521','T522','T525','T526','T541') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and left(der.Spell_Primary_Diagnosis,4)='M720' then 'N_dupuytr'
1O	Ganglion excision	when left(der.Spell_Dominant_Procedure,4) in ('T591','T592','T598','T599','T601','T602','T608','T609') and der.Spell_Primary_Diagnosis like '%M674%' then 'O_ganglion'
1P	Trigger finger release	when der.Spell_Dominant_Procedure in ('T692+HAND','T691+HAND','T698+HAND','T699+HAND','T701+HAND','T702+HAND','T718+HAND','T719+HAND','T723+HAND','T728+HAND','T729+HAND','Z894+HAND','Z895+HAND','Z896+HAND','Z897+HAND') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and der.Spell_Primary_Diagnosis like '%M653%' then 'P_trigger_fing'
1Q	Varicose vein surgery	when left(der.Spell_Dominant_Procedure,4) in ('L832','L838','L839','L841','L842','L843','L844','L845','L846','L848','L849','L851','L852','L853','L858','L859','L861','L862','L863','L868','L869','L871','L872','L873','L874','L875','L876','L877','L878','L879','L881','L882','L883','L888','L889') and der.Spell_Primary_Diagnosis like ('%I8[03]%') then 'Q_var_veins'
Z	ENT - Grommets for Children	When left(der.Spell_Dominant_Procedure,4) in ('D151','D153' and (s.AgeAtStartofSpell between 1 and 17 OR s.AgeAtStartofSpell between 7001 and 7007) Then 'Z ENT - Grommets for Children'
Z	ENT - Grommets for Adults	When left (der.SpellDominantProcedure,4) in ('D151','D153') And s.AgeAtStartofSpell between 18 and 120 then 'Z ENT - Grommets for Adults

Z	General Surgery - Benign Perianal Skin Tags	When left(der.Spell_Dominant_Procedure,4) = 'H482' then 'Z General Surgery - Benign Perianal Skin Tags'
Z	General Surgery - Cholecystectomy (Asymtomatic Gallstones)	When left(der.Spell_Dominant_Procedure,4) in ('J181','J182','J183','J184','J185','J188','J189','J211','J212','J213','J218','J219') and(der.Spell_Primary_Diagnosis like 'K802%' or der.Spell_Primary_Diagnosis like 'K805%') then 'Z General Surgery - Cholecystectomy (Asymtomatic Gallstones)'
Z	General Surgery - Hernia Repair	when left(der.Spell_Dominant_Procedure,4) in ('T191','T192','T198','T199') and (der.Spell_Primary_Diagnosis like 'K402%' or der.Spell_Primary_Diagnosis like 'K409%' or der.Spell_Primary_Diagnosis like 'K439%' or der.Spell_Primary_Diagnosis like 'K469%') and Age between 18 and 120 and der_procedure_all not like '%N132%' then 'Z General Surgery - Hernia Repair'
Z	General Surgery - Hernia Repair	when left(der.Spell_Dominant_Procedure,4) in ('T201','T202','T203','T204','T208','T209','T211','T212','T213','T214','T218','T219','T251','T252','T253','T258','T259','T261', 'T262','T263','T264','T268','T269','T271','T272','T273','T274','T278','T279') and (der.Spell_Primary_Diagnosis like 'K402%' or der.Spell_Primary_Diagnosis like 'K409%' or der.Spell_Primary_Diagnosis like 'K439%' or der.Spell_Primary_Diagnosis like 'K469%') and.Age between 18 and 120 and der_procedure_all not like '%G693%' and der_procedure_all not like '%H111%' and der_procedure_all not like '%G762%' and der_procedure_all not like '%H175%' then 'Z General Surgery - Hernia Repair'
Z	General Surgery - Hernia Repair	when left(der.Spell_Dominant_Procedure,4) in ('T241','T242','T243','T244','T248','T249') and der.Spell_Primary_Diagnosis like 'K429%' and Age between 18 and 120 then 'Z General Surgery - Hernia Repair'
Z	Ophthalmology - – Blepharoplasty	when left(der.Spell_Dominant_Procedure,4) in ('C121','C122','C123','C124','C125','C126','C128','C129', 'C131','C132','C133','C134','C138','C139','C161','C162','C163','C164','C165','C168','C169') and left(der.Spell_Primary_Diagnosis,4) <> ('H001') and der.spell_primary_diagnosis not like 'C4[3469]%' then 'Z Ophthalmology – Blepharoplasty'

Z	Ophthalmology - Cataract Surgery	when left(der.Spell_Dominant_Procedure,4) in ('C711','C712','C713','C718','C719','C721','C722', 'C723','C728','C729','C741','C742','C743','C748','C749','C751','C752','C753','C754','C758','C759') and left(der.Spell_Primary_Diagnosis,4) in ('H25','H26') then 'Z Ophthalmology - Cataract Surgery'
Z	Orthopaedics - Hallux Valgus	when left(der.Spell_Dominant_Procedure,4) in ('W151','W152','W153','W154','W155','W156','W158', 'W159','W591','W592','W593','W594','W595','W596','W597','W598','W599','W791','W792','W799') and der.Spell_Primary_Diagnosis like 'M201%' then 'Z Orthopaedics - Hallux Valgus'
Z	Orthopaedics - Hip Replacement for Osteoarthritis	when left(der.Spell_Dominant_Procedure,4) in ('W371', 'W378', 'W379', 'W381', 'W388', 'W389', 'W391', 'W398', 'W399', 'W931', 'W938', 'W939', 'W941', 'W948', 'W949', 'W951', 'W958', 'W959') and (der.Spell_Primary_Diagnosis like 'M15%' or der.Spell_Primary_Diagnosis like 'M16%' or der.Spell_Primary_Diagnosis like 'M17%') then 'Z Orthopaedics - Hip Replacement for Osteoarthritis'
Z	Orthopaedics - Knee Replacement for Osteoarthritis	when left(der.Spell_Dominant_Procedure,4) in ('W401', 'W408', 'W409', 'W411', 'W418', 'W419', 'W421', 'W428', 'W429', 'O181', 'O188', 'O189') and (der.Spell_Primary_Diagnosis like 'M15%' or der.Spell_Primary_Diagnosis like 'M16%' or der.Spell_Primary_Diagnosis like 'M17%') then 'Z Orthopaedics - Knee Replacement for Osteoarthritis'
Z	Orthopaedics - Ingrowing Toe Nail	when Spell_Primary_Diagnosis = 'L600' and left(der.Spell_Dominant_Procedure,4) in ('S641', 'S642', 'S681', 'S682', 'S683', 'S701') and (der_procedure_all Like '%Z906%' or der_procedure_all Like '%Z907%' or der_procedure_all Like '%Z506%') then 'Z Orthopaedics - Ingrowing Toe Nail'
Z	Urology - Male Circumcision	When left (der.Spell_Dominant_Procedure,4) = 'N303' then 'Z Urology - Male Circumcision'
Z	Urology – Vasectomy	When left (der.SpellDominantProcedure,4) = 'N171' Then 'Z Urology - Vasectomy'
Z	Acupuncture	When left (der.SpellDominantProcedure,4) IN ('A705', 'A706','Y331') Then 'Z Acupuncture'

2A	2A Diagnostic coronary angiography for low risk, stable chest pain	o LEFT(der.Spell _ Dominant _ Procedure,4) like '%K63[12345689]%' AND (apcs.der _ diagnosis _ all not like '%I20[01]%' AND apcs.der _ diagnosis _ all not like '%I2[12345]%') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2B	2B Repair of minimally symptomatic inguinal hernia	left(der.Spell _ Dominant _ Procedure,3)='T20' and der.Spell _ Primary _ Diagnosis like 'K40[29]%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2C	2C Surgical intervention for chronic rhinosinusitis	(apcs.der _ procedure _ all like '%Y76[12]%' OR apcs.der _ procedure _ all like '%E1[2-7][1-9]%'OR apcs.der _ procedure _ all like '%E081%')and der.Spell _ Primary _ Diagnosis like'J3[23]%'and APCS.Admission _ Method not like ('2%')
2D	2D Removal of adenoids for treatment of glue ear	apcs.der _ procedure _ all like '%E20[1489]%'and apcs.der _ procedure _ all like '%D151%'and (der.Spell _ Primary _ Diagnosis like'H65[2349]%' OR der.Spell _ Primary _ Diagnosislike 'H66[1349]%'OR der.Spell _ Primary _ Diagnosis like 'H681%' OR der.Spell _ Primary _ Diagnosis like'H69[89]%')and (apcs.der _ diagnosis _ all not like'%G473%' and apcs.der _ diagnosis _ all not like '%J32%' and apcs.der _ diagnosis _ all not like '%Q3[57]%')and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date)<=18 and APCS.Admission _ Method not like ('2%')
2E	2E Arthroscopic surgery for meniscal tears	left(der.Spell _ Dominant _ Procedure,3)='W82' and (der.Spell _ Primary _ Diagnosis like '%M23[23]%' or der.Spell _ Primary _ Diagnosis like '%S832%') and APCS.Admission _ Method not like ('2%')
2F	2F Troponin test	ecds.Der_EC_Investigation_All like '%105000003%' or ecds. Der_EC_Investigation_All like '%121870001%' or ecds.Der_EC_Investigation_All like '%121871002%' or ecds. Der_EC_Investigation_All like '%313724009%' or ecds.Der_EC_ Investigation_All like '%313616005%' or ecds.Der_EC_Investigation_All like '%314068007%' or ecds. Der_EC_Investigation_All like '%166794009%' or ecds. Der_EC_Investigation_All like '%105001004%' or ecds.Der_EC_ Investigation_All like '%784261000000103%'
2G	2G Surgical removal of kidney stones	(left(der.Spell _ Dominant _ Procedure,4) in ('M094','M098','M164','M261','M262','M263','M271','M272','M273','M278') OR left(der.Spell _ Dominant _ Procedure,3)='M28') and der.Spell _ Primary _ Diagnosis like '%N20[0129]%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120

2H	2H Cystoscopy for men with uncomplicated lower urinary tract symptoms	left(der.Spell _ Dominant _ Procedure,3)='M45' and apcs.sex=1 AND apcs.der _ procedure _ all NOT LIKE '%M45[1-4]%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2I	2I Surgical intervention for benign prostatic hyperplasia	l(left(der.Spell _ Dominant _ Procedure,4) like '%M61[123489]%'or left(der.Spell _ Dominant _ Procedure,4) like '%M641%'or left(der.Spell _ Dominant _ Procedure,4)like '%M65[1234589]%'or left(der.Spell _ Dominant _ Procedure,4)like '%M66[12]%'or left(der.Spell _ Dominant _ Procedure,4)like '%M68[13]%') and der.Spell _ Primary _ Diagnosis like'%N40%' and apcs.sex=1 and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2J	2J Lumbar Discectomy	left(der.Spell _ Dominant _ Procedure,4) in ('V331','V332','V333','V334','V335','V336','V337','V338','V339','V351','V358','V359','V511','V518','V519','V521','V522','V525','V528','V529','V583','V588','V589 ','V603','V608','V609')and (der.Spell _ Primary _ Diagnosis like '%M51[01]%' or der.Spell _ Primary _ Diagnosis like '%M54[134]%') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%') AND (der _ procedure _ all LIKE '%V55[12389]%')
2K	2K Lumbar radiofrequency facet joint denervation	der.Spell _ Dominant _ Procedure like '%V48[57]%' and left(der.spell _ primary _ diagnosis,4) in ('M518','M519','M545','M549') and (apcs.der _ procedure _ all like '%Z67[567]%' or apcs.der _ procedure _ all like '%Z993%') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2L	2L Exercise ECG for screening for coronary heart disease	OPA.Der _ Procedure _ All LIKE '%U194%' and isnull(OPA.Age _ at _ Start _ of _ Episode _ SUS,OPA.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2M	2M Upper GI endoscopy	**APC extract** left(der.Spell _ Dominant _ Procedure,3) in ('G16','G19','G45','G65','G80') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%') **OPA extract** left(der.Spell _ Dominant _ Procedure,3) in ('G16','G19','G45','G65','G80') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2N	2N Appropriate colonoscopy in the management of	**APC extract** (apcs.Der _ Procedure _ All like '%H22[189]%' or apcs.Der _ Procedure _ All like '%H68%') and apcs.der _ diagnosis _ all not like '%Z121%' And isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date)

	hereditary colorectalcancer	between 19 and 120 AND APCS.Der _ Procedure _ All NOT like '%H68[13]%' and APCS.Admission _ Method not like ('2%')
20	2O Repeat Colonoscopy	**OPA extract** (opa.Der _ Procedure _ All like '%H22[189]%' or opa.Der _ Procedure _ All like '%H68%') and ISNULL(opa.der _ diagnosis _ all,'') not like '%Z121%' And ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 AND opa.Der _ Procedure _ All NOT like '%H68[13]%'
2P	2P ERCP in acute gallstone pancreatitis without cholangitis	Refer to P.128 of Guidance (Codes are too lengthy to list)
2Q	2Q Cholecystectomy	Der.Spell _ Dominant _ Procedure like '%J18%' and der.Spell _ primary _ diagnosis like '%K851%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2R	2R Appendicectomy without confirmation of appendicitis	Der.spell _ dominant _ procedure like '%H0[12]%'
2S	2S Low back pain imaging	(opa.Der _ Procedure _ All like '%U05[45]%' or ((opa.Der _ Procedure _ All like '%U13[2356]%' or opa.Der _ Procedure _ All like '%U21[1267]%') and (opa.Der _ Procedure _ All like '%Z665%' or opa.Der _ Procedure _ All like '%O162%'))) and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2T	2T Knee MRI when symptoms are suggestive of osteoarthritis	opa.Der _ Procedure _ All like '%U133%' and (opa.Der _ Procedure _ All like '%Z846%' or opa.Der _ Procedure _ All like '%O132%') and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2U	2U Knee MRI for suspected meniscal tears	opa.Der _ Procedure _ All like '%U133%' and (opa.Der _ Procedure _ All like '%Z846%' or opa.Der _ Procedure _ All like '%O132%') and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2V	2V Vertebral augmentation (vertebroplasty or kyphoplasty) for	left(der.Spell _ Dominant _ Procedure,4)='V444' and der.Spell _ Primary _ Diagnosis like '%M80%'and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 AND (der _ procedure _ all LIKE '%V55[12389]%')

	painful osteoporotic vertebral fractures	
2W	2W Shoulder Radiology: Scans for Shoulder Pain and Guided Injections	**W(i) – scans for shoulder pain:** (opa.Der _ Procedure _ All like '%U13[23456]%' or opa.Der _ Procedure _ All like '%U21[1267]%') and (opa.Der _ Procedure _ All like '%Z81[23489]%' or opa.Der _ Procedure _ All like '%Z891%' or opa.Der _ Procedure _ All like '%Z54[289]%' or opa.Der _ Procedure _ All like '%Z68[89]%') AND opa.Der _ Procedure _ All NOT LIKE and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 **W(ii) – image guided injections for shoulder pain:** (opa.Der _ Procedure _ All like '%U13[23456]%' or opa.Der _ Procedure _ All like '%U21[1267]%') and(opa.Der _ Procedure _ All like '%Z81[23489]%' or opa.Der _ Procedure _ All like '%Z891%' or opa.Der _ Procedure _ All like '%Z54[289]%' or opa.Der _ Procedure _ All like '%Z68[89]%') AND opa.Der _ Procedure _ All LIKE '%W90[34]%' and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2X	2X MRI scan of the hip for arthritis	(opa.Der _ Procedure _ All like '%U133%' or opa.Der _ Procedure _ All like '%U211%') and (opa.Der _ Procedure _ All like '%Z84[389]%' or opa.Der _ Procedure _ All like '%Z902%') and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2Y	2Y Fusion surgery for mechanical axial low back pain	(left(der.Spell _ Dominant _ Procedure,4) like '%V38[23456]%' or left(der.Spell _ Dominant _ Procedure,4) like '%V404%') and der.Spell _ Primary _ Diagnosis like '%M54[59]%' and apcs.der _ diagnosis _ all not like '%M40[012]%' and apcs.der _ diagnosis _ all not like '%M41[01234589]%' and apcs.der _ diagnosis _ all not like '%M42[019]%' and apcs.der _ diagnosis _ all not like '%M43[01589]%' and apcs.der _ diagnosis _ all not like '%M872%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2Z	2Z Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children	No coding included
2AA	2AA Pre-operative chest x-ray	We have been unable to accurately identify diagnostic and procedure codes and produce activity figures. Exploring the option of using linked Diagnostic Imaging Dataset (DIDs) data, available later this year.
2BB	2BB Pre-operative ECG	We have been unable to accurately identify diagnostic and procedure codes and produce activity figures. Exploring the option of using linked Diagnostic Imaging Dataset (DIDs) data, available later this year.

2CC	2CC Prostate-specific antigen (PSA) test	No coding is available for the procedure, diagnoses or indications.
2DD	2DD Liver function, creatinine kinase and lipid level tests – (Lipid lowering therapy)	No coding is available for the procedure, diagnoses or indications.
2EE	2EE Blood transfusion	No coding is available for the procedure, diagnoses or indications.

EBI Phase 2 National Based Interventions policy: P. 96 -145
EBI_list2_guidance_050121.pdf (aomrc.org.uk)

Appendix 6 - Definitions

Definition of Clinical Thresholds

Clinical thresholds are a predetermined set of criteria that must be met before some procedures are considered. The threshold may be such that medication would deal with the problem. Surgery should be a last resort for a number of conditions and should not take place before considering and trying other non-surgical, reasonable options.

Definition of Commissioning

Assessing local needs, agreeing priorities and strategies, and then buying services on behalf of our population from a range of providers whilst constantly responding and adapting to changing local circumstances.

Definition of Individual Funding Request

An individual funding request is where prior approval for a patient's treatment is required due to that treatment or symptom criteria being outside of our approved commissioning policies and in such cases exceptionality will need to be proven.

Definition of Exceptionality

In order to demonstrate exceptionality the patient

1. Must be significantly different to the population of interest (i.e. patients with pulmonary hypertension and/or the subpopulation), and,
2. Be more likely to benefit from this intervention than might be expected than other patients with the condition

Appendix 6 - DEFINITIONS

AESTHETIC	Concerned with beauty or the appreciation of beauty.
ADENOIDS	Small lumps of tissue at the back of the nose, above the roof of the mouth
ANGIOGRAPHY	Imaging used to check blood vessels
ARTHROSCOPY	A type of keyhole surgery used to diagnose and treat problems with joints
ANTIGEN	A substance that induces the immune system to produce antibodies against it is called an antigen
BLEPHAROPLASTY	A type of surgery that repairs droops eyelids
COLONOSCOPY	A camera to check inside your bowels
COSMETIC	Relating to treatment intended to restore or improve a person's appearance
CHOLECYSTECTOMY	Surgical procedure to remove your gallbladder
CHOLANGITIS	Inflammation of the bile duct
CYSTOSCOPY	A procedure to look inside the bladder using a thin camera called a cystoscope
DUPUYTRENS	A condition when one or more fingers bend towards the palm
ENDOSCOPY	Procedure where organs inside the body are looked at using an instrument called an endoscope
GYNAECOMASTIA	A condition in the male in which the mammary glands are excessively developed.
CUTIS LAXA	A rare, inherited or acquired connective tissue disorder in which the skin becomes inelastic and hangs loosely in folds

GANGLION	Noncancerous lumps that most commonly develop along the tendons or joints of your wrists or hands
HALLUX VALGUS	Most common foot deformity of the big toe
HYPERPLASIA	An increase in the number of cells in an organ or tissue
LABIAPLASTY	A surgical procedure to alter the size or appearance of the labia minora.
LIPODYSTROPHY	A disorder of fat tissue.
LIPOSUCTION	A method of fat removal through suction.
LIPOMA	A benign lump/tumour composed of fatty tissue.
MENISCAL TEARS	Injury to the part of the cartilage of the knee
MEIBOMIAN CYST (CHALAZION)	A Chalazion is a firm round lump in the upper or lower eyelid caused by a chronic inflammation/blockage of the meibomian gland
MORPHOLOGIC	Relating to form and structure.
OSTEOARTHRITIS	Condition that causes joints to become painful and stiff. Most common type of arthritis
PERIANAL	Conditions that affect the rectum and anus
PLAGIOCEPHALY	Head flattened on one side causing it to look asymmetrical
PTOSIS	When the upper eyelid droops over the eye
RHINOPLASTY	A surgical procedure to change the shape or structure of the nose.
RHINOPHYMA	Enlargement of the nose with redness and prominent blood vessels.

TONSILLECTOMY	Removal of the tonsils
TRIGGER FINGER	A condition that affects one or more of the hands tendons, making it difficult to bend the affected finger
TROPONIN	Protein that is released into the bloodstream during a heart attack
VERTEBROPLASTY	Procedure in which a special cement is injected into a fractured vertebra

Appendix 7 – Links to South Yorkshire and Bassetlaw Individual Funding Request Policies

Barnsley CCG - Individual Funding Requests Policy

Bassetlaw CCG - Individual Funding Requests Policy

Doncaster CCG - Individual Funding Request Policy

Rotherham CCG - Individual Funding Request Policy

Sheffield CCG - Individual Funding Request Policy